State Medicaid Directors' Mid-Year Conference

Improving The HCFA—State Partnership

November 14–16, 1979

U.S. Department of Health and Human Services
Health Care Financing Administration

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

IMPROVING THE HCFA-STATE PARTNERSHIP

Conference Summary

Sponsored by:

The Medicaid/Medicare Management Institute

Health Care Financing Administration

Department of Health, Education, and Welfare

November 14-16, 1979

ORLANDO, FLORIDA

TABLE OF CONTENTS

TABLE OF CONTENTS - continued

PREFACE

HCFA's Medicaid/Medicare Management Institute (Bureau of Program Operations) sponsored a three day Mid-Year State Medicaid Directors' conference November 14-16, 1979, in Orlando, Florida. Two hundred and one people attended the conference, representing HCFA Central Office, eight HCFA Medicaid Regional Offices, thirty-nine States and the District of Columbia, several HEW Washington offices, and twenty-two private sector firms.

The purpose of this important conference was to improve the HCFA-State partnership. The agenda provided for an overview and discussion of: recent and planned program developments, major Medicaid initiatives and problems at Federal and State levels, and review of new and pending legislation and policies impacting Title XIX State agencies.

Conference presentations stimulated interest and reactions, as demonstrated by the questions and comments at the conclusion of each session. Topics covered were pertinent, comprehensive, and generated enthusiasm for further formal and informal discussions. Exclusive of Federal moderators, there were a total of 47 speakers and panelists representing 14 States and the Federal government.

High points of the conference were a major policy address by Leonard D. Schaeffer, HCFA Administrator, and a HCFA senior staff question and answer panel. Mr. Schaeffer discussed key Medicaid priorities, including child health strategies, long term care initiatives, and common Federal-State goals to promote the timely and cost effective delivery of quality health care services to the poor. He stressed the need for a sense of joint program responsibility and HCFA's efforts to simplify and clarify Medicaid regulations and policies, simplify and improve program operations, and develop an improved management information system to assess HCFA's performance. The panel members discussed, among other subjects, actions of each of their offices to recognize Medicaid's role in HCFA programs.

There was a consensus among the 201 registered participants that this conference was one of the most productive held to date. Besides providing an opportunity to learn about relevant Medicaid problem areas, it also provided an opportunity to share experiences among and between States, HCFA central and regional office staff and the private sector regarding methods for improving Medicaid operations.

This report is a compilation of major presentations made at the conference, including the senior staff question and answer panel, a summarized agenda, summary reports of conference seminars, and a list of participants.

SUMMARIZED AGENDA

IMPROVING THE HCFA-STATE PARTNERSHIP

November 14-16, 1979

TOPIC	SPEAKER/PANEL
Welcome	VIRGINIA M. SMYTH Regional Administrator Region IV/HCFA Atlanta, Georgia
Conference Objectives and Overview of Immediate Program Developments Confronting Federal and State Managers	MILDRED L. TYSSOWSKI Director, Bureau of Program Operations (BPO) HCFA Baltimore, Maryland
CHAP and EPSDT	ALICIA CORO, Moderator Chief, Consultation and Training Branch (CTB) Improvements Promotion Division (IPD) Medicaid/Medicare Management Institute (M/MMI) BPO/HCFA Baltimore, Maryland Panel: MARY TIERNEY, M.D. Acting Director, Office of Child Health Office of Special Programs/HCFA Washington, D.C. DIANE ROWLAND Special Assistant to the Administrator/HCFA Baltimore, Maryland
Cost Containment	WILL WOLSTEIN, Moderator Director, IPD/M/MMI BPO/HCFA Baltimore, Maryland

TOPIC	SPEAKER/PANEL
Cost Containment (cont'd)	Panel: PETER BOUXSEIN Deputy Director, Bureau of Program Policy (BPP) HCFA Baltimore, Maryland MARILYN J. KOCH Chief, Special Projects Section Division of Health Care Cost Containment Office of Reimbursement Policy (ORP) BPP/HCFA Baltimore, Maryland ROBERT F. SKERRETT Acting Deputy Commissioner, Division of Medical Assistance New York State Department of Social Services Albany, New York PAUL M. ALLEN Director, Medical Services Administration (MSA) Michigan Department of Social Services Lansing, Michigan
Research and Demonstration Activities	ALICIA CORO, Moderator Chief, CTB IPD/M/MMI/BPO/HCFA Baltimore, Maryland Panel: JAMES KAPLE, Ph.D. Acting Director, Office of Research Demonstrations and Statistics HCFA Washington, D.C.

TOPIC	SPEAKER/PANEL
Research and Demonstration Activities (cont'd)	RICHARD A. BERMAN Director, Office Health Systems Management New York State Department of Health Albany, New York CHARLES C. STOVER Commissioner, Massachusetts Rate Setting Commission Boston, Massachusetts
National Health Plan	MARTIN STANTON, Moderator Regional Medicaid Director Region V/HCFA Chicago, Illinois Panel: KAREN WILLIAMS Special Assistant to the Bureau Director BPP/HCFA Washington, D.C. DR. ROBERT C. BONHAG Special Assistant to the Secretary National Health Insurance Office of the Secretary/HEW Washington, D.C.
Fiscal Year 1980 Regulations Agenda Priorities	PETER BOUXSEIN
Medicaid Management Information	JOHN W. COYLE, Moderator Chief, Program Performance Review Branch Division of Reports and Analysis Office of Standards and Performance Evaluation (OSPE) BPO/HCFA Baltimore, Maryland

TOPIC	SPEAKER/PANEL
Medicaid Management Information (cont'd)	Panel: LINDA STELLA Program Analyst, Corrective Action Projects Division (CAPD) M/MMI/BPO/HCFA Baltimore, Maryland KAY MOSER Chief, Center for Health Statistics California Department of Health Services Sacramento, California JAMES ADAMS Associate Director for Management Reports Medical Service Administration Montgomery, Alabama
Common Coding Systems	WILL WOLSTEIN, Moderator Panel: WILLIAM HOGSTEN Director, Office of Methods and Systems (OMS) BPO/HCFA Baltimore, Maryland RICHARD L. MORRIS Regional Medicaid Director Region IV/HCFA Atlanta, Georgia BLANCHE G. McCULLOUGH Executive Assistant, Health Care Financing South Carolina Department of Social Services Columbia, South Carolina

TOPIC	SPEAKER/PANEL
Rural Health Clinics	CANDIDO SALAZAR, JR., Moderator Regional Medicaid Director Region VIII/HCFA Denver, Colorado Panel: LAMONT W. WILLIAMSON Director, Office of Program Administration (OPA) BPO/HCFA Baltimore, Maryland BERNARD J. TRUFFER Acting Chief, Health Organizations Reimbursement Section Division of Alternative Reimbursement Systems (DARS) ORP/BPP/HCFA Baltimore, Maryland WILLIAM L. BAKE Program Analyst, Division of Operations OPA/BPO/HCFA Baltimore, Maryland BARBARA D. MATULA Director, Division of Medical Assistance North Carolina Department of Human Resources Raleigh, North Carolina
Nursing Home Reimbursement	ALICIA CORO, Moderator Panel: ROBERT STREIMER Director, DARS ORP/BPP/HCFA Baltimore, Maryland JAMES L. MANGUS, M.D. Medical Director Division of Medical Care West Virginia Department of Welfare Charleston, West Virginia

TOPIC	SPEAKER/PANEL
Nursing Home Reimbursement (cont'd)	MIKE KOETTING Associate Director, Public Health Office of Health Financing Illinois Department of Public Health Springfield, Illinois
Medicaid Objectives and Issues	LEONARD D. SCHAEFFER Administrator, HCFA Baltimore, Maryland
MQC Error Rates and Causes	JOHN D. KENNEDY Regional Administrator Region I/HCFA Boston, Massachusetts Formerly Director, Bureau of Quality Control (BQC) HCFA Baltimore, Maryland
Performance Standards	MILDRED L. TYSSOWSKI
Medicaid Quality Control-Base Period Indicators, Michel Amendment and Corrective Action	RICHARD L. MORRIS, Moderator
	Panel:
	JOHN BERRY Acting Director Office of Quality Control Programs BQC/HCFA Baltimore, Maryland
	MARY S. KENESSON Director M/MMI/BPO/HCFA Baltimore, Maryland
	ARTHUR A. PERGAM Director, CAPD/M/MMI/BPO/HCFA Baltimore, Maryland
	PETER M. BLOOMSBURGH Administrator, Medical Assistance Program Illinois Department of Public Aid Springfield, Illinois
Program Performance Standards and State Assessments	ALICIA CORO, Moderator
	Panel:
	JOHN JANSAK Director, OSPE/BPO/HCFA Baltimore, Maryland

TOPIC	SPEAKER/PANEL
Program Performance Standards and State Assessments (cont'd)	BARBARA D. MATULA BRUCE KOZLOWSKI Acting Director, Office Support Services MSA/Michigan Department of Social Services Lansing, Michigan
MMIS Performance Standards, NTAG and MMIS Task Force Report; Timely Claims Payment	JOHN W. COYLE, Moderator Panel: WILLIAM HOGSTEN NEWTON H. DIKOFF Director, Division of Standards OSPE/BPO/HCFA Baltimore, Maryland HOWARD W. STANSBERRY Medical Services Assistant, Department of Institutions Social and Rehabilitative Services Oklahoma City, Oklahoma RICHARD W. MOSS Acting Chief, Systems Planning Branch Division of Systems Planning and Development OMS/BPO/HCFA Baltimore, Maryland
Medicaid Budgeting, Financial Management and Administrative Costs	WILL WOLSTEIN, Moderator Panel: LAMONT W. WILLIAMSON DENNIS J. FISCHER Director, Office Financial Management Services Office of Management and Budget/HCFA Washington, D.C. CHARLES J. SCHREIBEIS Director, Division of Budget OPA/BPO/HCFA Baltimore, Maryland

TOPIC	SPEAKER/PANEL
Medicaid Budgeting, Financial Management and Administrative Costs (cont'd)	WILLIAM GEFELL Program Analyst, Division of Operations OPA/BPO/HCFA Washington, D.C.
State Medicaid Directors' Council Report	GLENN JOHNSON Chairman, State Medicaid Directors' Council Director, Bureau of Utilization Review Pennsylvania Department of Public Welfare Harrisburg, Pennsylvania
Deputy Administrator, HCFA and The Bureau Directors - Question and Answers Panel	RICHARD W. HEIM, Moderator Director, Office of Intergovernmental Affairs HCFA Baltimore, Maryland EARL M. COLLIER, Jr. Deputy Administrator/HCFA Baltimore, Maryland EDWARD L. KELLY Deputy Director, Health Standards and Quality Bureau/HCFA Baltimore, Maryland MILDRED L. TYSSOWSKI JOHN D. KENNEDY PETER BOUXSEIN PETER D. FOX Director, Office of Policy Analysis Office of Legislation and Policy/HCFA Washington, D.C. JAMES M. KAPLE, Ph.D.
Closing Remarks	MARY S. KENESSON

Conference Objectives and Overview of Immediate Program Developments Confronting Federal and State Managers

Mildred L. Tyssowski
Director
Bureau of Program Operations
HCFA
Baltimore, Maryland

MRS. TYSSOWSKI: The overall purpose of this conference is to improve our ability to handle current and potential Medicaid management issues confronting HCFA in the States. We hope that the in-depth and open communication between State and Federal officials at the different sessions throughout the conference will help us learn more about some of the problems we are facing.

In planning this conference, we had a planning committee of State representatives and HCFA staff. In determining the conference agenda, this committee decided that the issues relative to the management of the Medicaid program could best be addressed by directing the presentations to the following objectives:

(1) A discussion of major Medicaid initiatives and problems at both the Federal and State levels;

(2) A review of new and pending legislation and policies, and their impact on the program;

(3) Sharing experience and methods for improving the management of Medicaid operations; and

(4) An overview of recent and planned program developments which impact on all Medicaid State agencies.

The agenda also provides the State Medicaid Directors an opportunity to meet in a closed session on Thursday. As a result of that session, we expect recommendations will be presented to the Administrator for HCFA to address.

My assignment this morning is to review immediate program developments confronting Federal and State managers, legislative, policy, and operational issues, the status of Medicare/Medicaid integration projects, and HCFA goals for Fiscal Year 1980.

First, I want to discuss those integration projects which have a very high priority in our Fiscal Year 1980 work plans.

Speaking of integration projects, I was delighted to find that we have another first at a State Medicaid Directors Conference. We have in attendance here today, the co-chairmen of the Carrier Representative Group (CRG) and the Fiscal Intermediary Group (FIG) in the Medicare program. Co-Chairmen of the Carrier Representative Group, Gene Carter of Travelers and Chuck Stewart of California Physicians Service, are representing CRG and from the Fiscal Intermediary Group, Meritt Jacoby of the Blue Cross Association, and Ben Patterson of Mutual of Omaha.

I think it's a good forerunner to talk about where we stand with the integration projects and where we hope to go in the current year.

First, we hope to complete several of the integration projects that were started over a year ago. We feel that a real benefit will accrue to the providers of health service when, as a result of these projects, we are able to remove some of the duplicating demands of the Medicare and Medicaid programs.

Also, as we consolidate certain administrative processes in those programs, savings in Federal and State monies should result.

One of the projects that is in the final stages of implementation is the common auditing of hospitals. This effort builds on common auditing agreements that have been negotiated between the Medicare intermediaries and the Medicaid State agencies.

As of December, 1978, there were 33 States with common audit agreements in effect on a cost sharing basis. Under the new program, which was effective October, 1979, there will be a free exchange of information between the Title XIX State agencies and the Medicare intermediaries.

One exception is that States will be charged on an incremental basis for any special audit informational needs.

We held a regional conference in Denver on July 23 - 25, to review and discuss the benefits of this project. One of the principal benefits of this project has been a savings of $6 million by the States that have been participating in the common audit program.

This figure is based on current estimated costs incurred by States for the cost sharing of audit information from Medicare interemediaries. From your perspective, it is a $6 million saving to the States that have been participating in common audit agreements; but, it is really a $6 million loss in revenues to the Medicare trust funds.

However, we feel that if you add total Federal and State expenditures, the savings should result from the elimination of certain duplicating efforts.

Also, we believe that the free exchange of information should expedite the receipt of audit information by the States and lead to more timely and accurate settlement of costs claimed by institutions.

An informational memo, HCFA IM-79-29, was sent to the State Medicaid Directors in August, 1979. This document provided specific information relating to the common audit program.

The regions have begun to process the negotiating agreements, and we are monitoring their status on a flow basis.

One further step remains to complete the common audit project. That step is to establish a requirement that the audit conducted by the States not duplicate the Medicare intermediary audits, which is the information that is now furnished free of charge.

To assure that such duplication does not occur, a regulation will be published which makes Federal financial participation unavailable for any duplicating audits performed by the States.

You may be interested to know that this Congress might enact legislation which would mandate the use of Medicare audit information by Medicaid State agencies. Such legislation has been reported out of both the Ways and Means Committee and the Senate Finance Committee.

Closely related to the common auditing effort is the common overpayment monitoring system. Flowing out of the audit and other processes will be the identification of providers who owe money to both programs. Hopefully, a coordinated collection effort can be made.

Computerized systems, similar to the one in effect for Medicare, will be developed to track the collection of Medicaid overpayments. A regulations proposal to establish the overpayment monitoring system should be published for comment by March, 1980. This regulation will also deal with the difficult issue of what constitutes a Medicaid overpayment, as far as recovery of Federal funds is concerned.

While we are working on this regulations proposal, we are simultaneously working on a design of a computer system which will process and display the required data on Medicaid overpayments.

In addition, supplementary forms to the HCFA 64, Quarterly Statement of Expenditures Report, are being designed. Medicaid people from several States have been invited, through the Medicare and Medicaid Integration Project Steering Committee, to assist in this planning process.

Another project related to audits and overpayments is called the joint offset procedure. The idea of this project is to offset an overpayment in the Medicare program against the Federal portion of a Medicaid payment due the same provider under the Medicaid program, and vice versa.

Because of statutory program differences, it is not possible to use offset to collect overpayments of one program from the other. Therefore, this item will be contained in HCFA'S Fiscal Year 1981 legislative proposals.

I would like to turn to some of the integration projects that deal with claims processing. I recently learned that half a billion claims in the Medicare and Medicaid programs are processed each year. This is a tremendous volume of paperwork.

As you know, most of these claims come from providers serving both programs. This commonality of providers and the large volume of paperwork has led to several claims processing projects.

One of them was to establish a common provider identification number. We have encountered problems with this project, particularly in finding an identification system for physicians.

So, we are presently trying to see whether our current systems have sufficient ability to identify providers without requiring some unique identifier. If our evaluation supports this theory, we may not need a common provider identification number because we can relate the information in our files through other processes.

A very important effort for Medicaid and Medicare program administration, including the services of the PSROs, is to develop uniform systems for coding diagnoses and procedures.

HCFA has established a uniform diagnostic coding system, the ICD-9-CM, which is currently being installed in State processing systems. I am aware that questions have been raised as to whether we need to use all five digits of ICD-9-CM. This issue is being addressed in HCFA Central Office.

We are now focusing on the development of a common medical procedural terminology and coding system. HCFA is attempting to find a single procedural coding system that will satisfy not only the needs of HCFA programs, but those of third party payors, providers, medical records professionals, and statisticians. With all those groups involved, this is no small order.

A work group consisting of HCFA representatives and interested parties from the health care field have been meeting to see if such a system is feasible. Their formal recommendations were submitted to HCFA on November 7.

This committee concluded that, in the short run, no single system is feasible. They recommended that an umbrella system be established to allow coordination of ICD-9-CM procedure codes for hospitals, with CPT-4 procedure codes for physicians, when such correlation is necessary. HCFA and the Public Health Service are currently evaluating this recommendation.

The development of a common claims form to be used by providers in the Medicare and Medicaid programs, and in private insurance programs, is a current priority.

In regards to noninstitutional providers, the Bureau of Program Operations has prepared a position paper to the Administrator regarding the use of a revised version of the American Medical Association health insurance claim form for Medicare and Medicaid.

Some of the HCFA regional offices have been urging the use of this form in several States, with reasonable success. We will be consulting with the State Medicaid agencies before mandating any use of this form.

In regards to the institutional providers, HCFA recently issued an RFP to evaluate the effect of a uniform bill on provider costs and operations. Systemetrics, a California-Maryland consulting firm, was named as the primary contractor in this evaluation.

The main objective of the study is to measure the costs of the billing functions in the hospitals before and after implementation of the proposed common claims form, the UB-16. The UB-16 is an institutional provider billing form developed under the sponsorship of the American Hospital Association.

It is intended to replace the numerous bills used by providers to request reimbursement from major third party payors. The basic idea is to enable the provider to prepare one billing form for each patient stay rather than several.

Adoption of this concept should result in lower provider billing costs. Conversely, however, processing costs for Medicare intermediaries should be somewhat higher, primarily because the form is more detailed and more complex than current Medicare billing forms.

The Bureau of Program Operations is now conducting tests of the impact of UB-16 on intermediary operations in conjunction with some of the broader Statewide tests involving major third party insurance payors.

It is still too early to assess data from either the hospital evaluation process or the intermediary evaluation process.

The use of the common claims form, common coding systems, or common identifiers are all important building blocks to two other important efforts with which we are concerned. One is the integrated handling of crossover claims. The other is an experiment in the integrated processing of Medicare and Medicaid claims by a single fiscal agent.

As you know, crossover claims arise when services are rendered to beneficiaries entitled to both Medicare and Medicaid. Frequently, Medicare is responsible for reimbursement of the entire claim except the deductible and coinsurance amounts which are paid by Medicaid.

As a result, providers of services must often bill both programs. Our long-range goal is to eliminate the unnecessary dual billing and dual claims processing activities. We need to develop procedures that Medicare payors can use to pay providers for deductibles and coinsurance on behalf of the States.

The States would subsequently reimburse the Medicare program. In addition, we also have to develop mechanisms for States to monitor the accuracy of payments made on their behalf by the Medicare contractors.

By mid-1980, we expect to have demonstrations with interested States to test and refine procedures. The design of these demonstrations is now underway, and initial contacts with States on this project are expected to begin within the next month.

You may be familiar with the recent GAO report on Medicare contracting that proposes the enactment of legislation to authorize Medicare contractors to handle crossover claims except where States can demonstrate they can do it more effectively.

The problem of dual filing of claims by providers can be solved by improving our ways of exchanging claims information, not only between Medicare and Medicaid, but with third party payors as well. Our long term objective is one claim from a beneficiary which can serve as a claim for all payors.

With respect to the exchange of data, we are currently developing magnetic tape specifications for use in the automated exchange of claims processing information between Medicare and Medicaid. The specifications will provide for data elements needed by both programs to process the claims. It will enable the Medicare contractor to advise the Medicaid processor what actions were taken on the claims.

We expect greater coordination between the two programs to be fostered as a result of this project. Also, we expect to remove the present 15 cents-a-claim charge to Medicaid States for Medicare data. Such action should further foster the use of Medicare claims information.

The theme of tomorrow's meeting will be program performance and accountability. Therefore, I will defer until then a discussion of our current efforts in setting standards and evaluative mechanisms.

I would like to note, however, that we believe much needs to be done to establish performance standards for Parts A and B of Medicare, and performance standards for Medicaid. We also need to improve our methods of assessing performance before we can realize the potentials for integration of these standards and assessment approaches.

Therefore, the integration projects that are related to performance standards and common assessment approaches are still in the planning stage. However, there is a common thread throughout the assessment techniques which will be used to establish standards for both the Medicare and Medicaid programs.

Thus far, I have discussed the integration projects that are receiving priority attention in the Bureau of Program Operations. One additional priority project is the effort to improve the explanation of Medicare benefits, the EOMB.

A revised form is being tested with beneficiaries, and we are also obtaining Medicare contractor input on the proposed revision. When we complete this phase we will touch base with State agencies to determine the feasibility of using a similar type form for Medicaid.

A very high priority integration project for HCFA is the uniform reporting system for providers. Jim Kaple, who heads up the Office of Research, Demonstration and Statistics, will be leading a panel discussion on our progress in this very important effort.

I would now like to move away from the Medicaid/Medicare integration projects and talk about some other activities that occupy much of our time and attention, namely, the Medicaid grants budget and procurement activities.

As far as the budget is concerned, we anticipate considerable attention on the Medicaid budget during the next session of Congress. We expect that the President will submit to the Congress a request for a very large supplemental appropriation for Fiscal Year 1980.

Our Fiscal Year 1980 appropriation, when it is finally enacted, will total $12 1/2 billion for Medicaid grants. We know now that this amount is insufficient to meet our matching needs. We had to borrow from Fiscal Year 1980 funds to cover the shortage of Fiscal Year 1979.

As a result of the shortages that occurred in 1979 and in 1980, we will need substantial supplemental funding. Of course, this will raise many Congressional queries on the overall administration of the Medicaid program.

The question is, "Why are we in such a shortage situation?" The principal reason appears to be that we have been double counting the savings in the Medicaid program that result from such management improvements as the installation of the MMIS, more aggressive efforts in third party liability recovery, and other improvements.

Our method of estimating at the national level was to develop a national model by using gross assumptions for utilization of medical services, the degree of inflation, and the changes in the size of the recipient population.

Once the estimates for that national model were developed, they were tested against the State estimates. State estimates were used basically as a test for reasonableness.

The next step was to make certain adjustments for new initiatives, such as more effective claims processing and reduction in eligibility errors. The fallacy in this method of developing our grants appropriation budget requests was that when we made this test against the State estimates for reasonableness, we did not take into account the fact that the States, due to their own budgetary pressures, had included in the estimates those savings to flow from MMIS, reduction in eligibility errors, and so forth.

At least this is our current theory, after talking with many States about the development of their budgets and analyzing the situation nationally. As a result, we are now reviewing our entire method of preparing the national grants appropriation request.

Another activity that occupies much of the time of many State and HCFA officials relates to various procurement activities; for example, the procurement of fiscal agents to handle all or part of Medicaid operations, procurements of data processing equipment, and management consultant services.

These procurements are becoming an area of increased interaction between HCFA and State agencies, particularly as we move into implementation of MMIS in practically all of our States.

Those of us with a Medicare background have experienced quite a learning period in contracting procedures and practices, in subcontracts that Medicare contractors enter into for data processing, and experiments with a competitive approach to awarding primary contracts. I know that several States have also been through a learning period in their processes of awarding fiscal agent contracts.

I am hopeful that we can pool our knowledges and experiences and work in a cooperative effort to arrive at the most effective procurement approaches.

We believe that much benefit will accrue to both Medicare and Medicaid administration by promoting competition. We also think it would be beneficial for HCFA to be involved in the procurement processes of the States in the early stages, rather than late in the process when any HCFA objections might create grave problems.

We are anxious to explore why we do not have, in our view, adequate competition in both Medicare and Medicaid contracts. We have considered having a conference with several organizations that have participated in the bidding process, or wish to do so in both programs, to determine some of the reasons that companies may hesitate to enter into competition. We would also like to discuss what we can do about our own processes that would improve competition.

As of March, 1979, there were 36 States that had fiscal agent contracts. Although there has been competition in the majority of the awards of these fiscal agent contracts, we believe much more can be done. We also want to prevent an increase in the small number of fiscal agent contracts which are becoming open-ended through noncompetitive renewal.

We are in the process of revising the Federal regulations pertaining to State Medicaid contracts. Basically, the revision would, first, renew the blanket requirement for Federal approval of expenditures of $100,000 or more, prior to the execution of the contract. Actually, we are going to advise the Office of Management and Budget that this requirement is really not allowable.

Secondly, the regulation would permit HCFA to approve the advance planning document in the earlier stages of the procurement process. In that review and approval process HCFA would review the State's justification for the need to contract, the description of the procurement process to be followed, principal features of the contract, the cost-benefit analysis regarding the advantage of contracting as compared to not contracting, and a list of the

major tasks involved in the procurement process, for example, the advertising plan to inform potential qualified bidders of the procurement, and the persons responsible for each of these major tasks.

HCFA would review and comment on the RFP, the evaluation criteria, the report of the State selection committee, and the proposed final contract. If HCFA determines that one of these elements fails to meet Federal requirements, it would be subject to prior approval by HCFA. Approval under these conditions would result only from a serious breach, and we presume they would be infrequent.

HCFA is also developing a model RFP contract and other documents to assist States in their procurement processes. We are also proposing a sole source procurement regulation which would provide for prior approval by HCFA of noncompetitive contracts over $10,000, noncompetitive contract extensions or renewals, and awards over $10,000 where only one bidder offer has been received in response to an issuance of an RFP.

While we are on this subject of fiscal agent contracts, I would like to tell you a little about HCFA's Washington, D.C., MMIS fiscal agent management plan.

Shortly after taking office this year, Mayor Barry, of the District of Columbia, met with the HEW Secretary to discuss the District's Medicaid program. The Department's annual reviews of the District's Medicaid program have repeatedly identified serious deficiencies in program management.

A solution to these problems included immediate efforts to install the MMIS and to secure the services of a fiscal agent with proven experience in managing such a system.

To help the District achieve both of these objectives, the Secretary gave this endeavor the highest priority and assigned responsiblity for its successful execution to HCFA. HCFA recommended that the District, with our assistance, initiate immediate efforts to develop a single contract for the installation of an MMIS and for a fiscal agent.

A task force was established, and the director is on the Bureau of Program Operations' staff. An initial version of the RFP was ready for review by the task force last week. By working together, we think the District can issue an RFP by December 31, 1979. The (winning) contractor must complete installation by December 31, 1980. After a brief transition period, possibly 90 days, the new fiscal agent will process all claims, using the MMIS system.

We view this effort with enthusiasm and optimism. In addition, we feel that this approach to contracting will result in the District getting a good contract at a good price.

Although we do not have the manpower resources to give States as much assistance as we are providing D.C., we are anxious to be of help in State procurement activities wherever it is possible.

In summary, I hope I have given you a feel for some of the major operational priorities that we will be working on during the current fiscal year.

Medicaid Objectives and Issues

Leonard D. Schaeffer
Administrator
HCFA
Baltimore, Maryland

MR. SCHAEFFER: This morning, I want to touch on a few key priorities that I feel are especially significant and then briefly discuss some areas of concern to you - our child health strategy and long term care initiative. I will try to be brief, because I'd like to spend whatever time we can this morning responding to your questions.

As the joint administrators of the Medicaid program, we share a common goal: to promote the timely and cost-effective delivery of quality health care services to the poor who are eligible for Medicaid. Achieving this goal is not an easy task for any of us. But we have a responsibility to the 23 million Americans eligible for the program, who depend upon us to finance their health care services. And we share a common dedication to meet that responsibility.

We have yet another responsibility, and, particularly in Washington, it grows every day. I know you feel it in the States. I'm speaking of the Federal and State legislatures' continuing concern over the prudence with which we manage these programs. At the Federal level, it is getting much more intense.

In order to meet our responsibilities, we are taking a variety of actions to improve the way the program operates. Many people are here from our Central Office and the regions. This indicates our concern to work as partners with you, to make sure that our ideas make sense to you, and to make very certain that we understand what you are doing in the various States that can be helpful and effective across the country.

We need your support, we need your cooperation, and we need a sense of joint responsibility for the program.

I'd like to talk about three areas of operational improvements: (1) our efforts to clarify regulations and policy, (2) our efforts to simplify program operations, and (3) our attempts to develop a better management information system to assess performance. The latter has become a Congressional issue. Senator Schweiker has introduced a bill which would require all States to have Medicaid Management Information System (MMIS) systems. This is the direct result of frustration over the lack of good national data on Medicaid.

We're trying to simplify our regulations. This is an HEW-wide goal. We have completed a regulation recodification effort which clarifies the language in Medicaid regulations. We really haven't gotten to the hard part yet, which is to see where we can simplify and improve the policy inherent in those regulations.

We will be soliciting your comments in that process. It is very important that you understand how we are going about this task. We're trying to open up our process. We will develop and publish an agenda of regulations (of the things we intend to do) before we actually do anything. The issues to be addressed as well as the order we will follow will be published for your use.

We then go through a public process of publishing an NPRM. We have to receive, by law, comment on the NPRM before we can publish a final regulation.

I urge you to be sensitive to this process and to participate in it, particularly the agenda-setting, because we may, indeed, select the wrong things to do. You have a vested interest in trying to turn us around, if we're aimed in the wrong direction, in terms of which regulations are most important to take up first.

In terms of improving and simplifying program operations, the most important thing we have to do is to develop clear benchmarks for evaluating our performance as managers, to set goals, and evaluate whether we achieve those goals.

Many of you have done much better jobs in your States, in either the whole program or parts of programs, than we've been able to do nationally. We are going to learn as much as we can from your experience. But, from the Federal level, the Congress of the United States does not see Medicaid as 54 different programs. They see it as a $12 billion Federal expenditure, and growing. They're concerned about how that money is being used. It is very difficult for us to explain this when we don't have a set of objectives, goals, and standards to measure national performance.

In this process of developing and setting standards, we expect State participation. We also expect to phase them in. In other words, to ensure there will be time available for States to meet the standards. The pressure is on all of us to demonstrate to the Congress and the public that the monies made available to our programs are being used appropriately and prudently in a financial sense, and that people are receiving appropriate services.

To measure our performance objectively, we need better information. One of the very sad things that happens in Congressional hearings is that AFDC program people explain how good a job they are doing and lay out all the data they have to demonstrate progress over time. The Medicaid program does not have that kind of a history in terms of program statistics, particularly in the area of quality control and error rates. We are at a terrible disadvantage because we're not able to demonstrate, from a national perspective, the progress we've made.

Many States have enviable records, but I can't read off to Congress 54 different ways of describing a program, and of measuring success or improvement. It just doesn't fly. Therefore, the ability to build management information systems that describe the program to the people who are paying half the freight -- Congress -- is very important. The basis for doing this, of course, is an agreement that we reach as to appropriate standards and appropriate definitions for the kinds of things we're trying to do, and to establish adequate objective measures of performance.

In this process we will try to minimize whatever burden is associated with collecting and reporting information. But, we must improve the timeliness of the information we get from the Medicaid program as well as the accuracy and comparability of information. Inability to compare States is a terrible handicap because each Federal legislator wants to know how his or her State is doing and is interested in a comparison. It would be very helpful if we could provide that information. I also think it would be helpful to you to have some sense of what national norms are and of what has been achieved in other States.

When we try technology transfers, we very frequently find that what is successful in one State is not necessarily transferable to another because of differing ways of viewing problems, aggregating information, and processing transactions.

We intend to use the Medicaid Minimum Data Set (MMDS) as the statistical base for our performance evaluation, and we intend to use the Medicaid Management Information System (MMIS) as the source of data for management information, as well as a system for paying claims. Over the next two to five years, I hope you'll see the expansion and the improvement of MMIS-type systems, which we can all use to provide output-oriented standards of performance and to manage information for State and national use.

The importance of MMIS has been recognized by the Congress. As I said, the Senate has passed the Schweiker bill which will require all but the smallest States to implement MMIS-like systems. Today, we have 27 States with MMIS systems. We hope to approve 11 more this year. But, we're having trouble in some of the major States, and Congress is very concerned about that. We will have pressure on all of us to demonstrate why, after a tremendous expenditure of money for MMIS, we don't have many of the major States up and running under automated systems that are acceptable in terms of processing standards and the management information they generate.

Information and claims processing systems will be a major priority for us in the coming year. MMIS requirements will be expanded to bring about the kinds of things that we think MMIS systems ought to do. Performance standards will be introduced.

We're depending on the National Technical Advisory Group (NTAG) to help us develop those standards. They met last week and developed some evaluation criteria and procedures for recertification. That is a very important process. We would like to see MMIS-type funding (90% match for development, 75% for operations) expanded. We also want to provide more opportunities for funding innovative approaches. We're going to look at the output (the results) of these systems, rather than at the conformance of the design and coding to a pre-set standard. We're going to be back every two years to recertify. We must make sure those systems work. Today, a number of States have MMIS systems that have been funded, but we're just not getting the results. We can't tolerate that in terms of the people who are depending on us to use that money appropriately.

We'd like to see MMIS funding expanded. We'd like to provide funding on a module-by-module basis if possible. We'd like to help you in every way we can, but we must get the results. The certification/recertification process will be the way we guarantee that results are being realized.

We must also, at both levels, do a better job of using data that the MMIS systems already generate. In many States there is still great and appropriate concern over the volume of paper that MMIS systems kick out, particularly MARS and SURS. I've heard stories of rooms full of computer printouts that no one is able to deal with.

It's incumbent on both of us to be reasonable about the process and adjust those programs and systems so that the really bad actors are identified and dealt with. The relationship with Section 17 units is important. Congress is very concerned. They are very proud of that program. They think

they've solved the problem of fraud in Medicaid with the Section 17 units. I don't know that they've quite done that; but there have been some outstanding successes in those States where we have good cooperation between the Medicaid agency and the Section 17 unit. In many States, though, Medicaid programs are not providing the kind of information necessary for the Section 17 units to do their job. If we're going to be able to defend our role as providers of services in an efficient and prudent manner, that gap must be closed.

From a national perspective, we're very interested in using the data from MMIS systems. However, the greatest benefit should be at the local level. HCFA is sponsoring a series of four workshops on management information for Medicaid across the country. I hope they will be helpful to you in making better use of those systems.

On the subject of operational improvement initiatives, it is important to mention a few things we believe will be critical for the future. Common diagnostic and procedural coding is critical to us. We are unable to compare and to analyze nationally much of the data now available because we don't have these common systems.

We want common diagnostic and procedural coding conventions for Medicare and Medicaid. We are convinced that, in that process, the Blues and the private insurance companies will join with us. We'll have a series of national conventions, so that we can talk to each other about what's going on in health service delivery.

We're also very interested in the common audit approach. There is about a $6 million savings involved for States. Some excellent work has been done in the States on overpayment recovery systems. We can learn from that and improve our way of doing business in this area. Common billing is something that we've been testing across the country. We really want to move ahead on that.

Another initiative is seeking better ways of processing cross-over claims, permitting Medicare contractors to pay the deductible and co-insurance for someone eligible for both programs, with Medicare being reimbursed later by the States. Yet another effort is toward uniform reporting from institutions, so we can compare and understand the incredible variances in costs in hospitals, SNFs, and other institutions; and have a better approach to health data collection and dissemination systems.

I am astounded with the very different ways we collect the same information from different sources. You're collecting information as are the Blues, the privates, the Medicare program, PSROs, and HSAs. We're all looking at the same thing, but we look at it and describe it differently. In my view, we're wasting a great deal of money. If we could develop more integrated approaches, we could save money and have a better understanding of what's really happening - not just our little slice of the action, but across the board.

One area where operational improvements are especially needed is in that part of the program related to erroneous Medicaid payments. There is tremendous emphasis on that in the Congress and in the press. Our MQC and program validation efforts are aimed at these concerns.

Tomorrow, Senator Moynihan is holding a hearing in which he will offer us an opportunity to explain what we're doing and what our hopes are for improving quality control in the future. The hearing will address Medicaid, AFDC, and SSI.

We will be making the point tomorrow that in our opinion the press has overplayed the incidence and the problems associated with fraud, abuse, and waste. We will point out that our real concern in the Medicaid program is not to catch crooks, but to make sure that we finance services for eligible individuals, and that those individuals receive the services.

The problem is that public perception is one of a very undisciplined program. The only way that we can react to that and demonstrate that we are on top of the issues is with some kind of a factual base, some set of statistics, and some set of descriptions that can give the Congress a sense of where we are in terms of system abuse.

We are very aware of the problems you have in collecting and reporting MQC data. We are grateful to those States that have made extraordinary efforts to collect the information and get it to us. The absence of some kind of a data base shocks Congress - even our friends there -- because of our inability to describe in aggregate terms how this program operates.

We have very gross statistics, and we have very few valid useable statistics to describe improvements in quality control. I don't think it's a matter of not having tried. There are States that have done extraordinary jobs, but we have not been able to get our act together and describe ourselves as a national program.

I have talked today about my perceptions, from where I sit, because that's where I sit. I don't, in any way, mean to imply that the Federal government is running this program or wants to run it on some kind of unilateral basis. Medicaid is a State-Federal partnership. I believe the differences among States and the different ways of doing business have led us to discovering improvements we may not have been aware of had we tried to do it uniformly across the country.

But you must have a sense of how weak we appear to the Congress when we can't describe some of the simplest characteristics of our program on a national basis. We do not have a national error rate, we do not have a history that can describe improvements nationally to the Congress. We talk about specific States, but Congress is paying half of the freight, and they are less than thrilled with our inability to speak to them on the issues that currently concern them.

Thus, we are concentrating on refining our MQC system to improve data accuracy and to validate the national numbers. Right now, it's very difficult to do. We want to develop better reporting systems, and we want to try to simplify the whole process - I think it's overly cumbersome. We'd like to clarify a variety of review and operational policies that I believe to be of concern to many of you, and we'll try to provide more and better technical assistance to those States requesting it.

The corrective action process is really the payoff. Assuming we can get all the data and assuming we can understand what our problems are, it seems to me we would want to use the information to improve the program. We would like in our Corrective Action Projects Division of our Medicaid/Medicare Management Institute, to help you all we can.

However, HCFA's experience is quite clear. Unless a State is interested in assistance from the Federal government, our efforts really don't do much good.

It seems to me we must devote as much time and intelligence as we can to analyzing MQC information, jointly defining the problems, and working together to take corrective action. Many of you have done that and I'm sure will continue to do that without our help. It certainly doesn't have to involve Federal corrective action program staff; but to the extent you can use our help, we'd like to make it available. We just need a signal from you that you think we can be of assistance.

In addition to MQC, you'll hear a lot today about our program validation efforts. Program validation is an audit process aimed at detecting potential fraud and abuse among individual providers. It's an effort we will undertake to look at individual providers, and to identify those procedures -- State contractor procedures or Federal policy -- that may lead to systems abuse, and to try to take corrective action.

Our plan for the year is complete. We will study at least 200 different providers across the country, and the activity will expand as we gain experience. We see this as a tool to try to understand where we have procedural or policy weaknesses, and to improve our provider relations in the management of the program.

We share a responsibility for knowing what our problems are, what causes them, and how to deal with them. It is critical that we be able to identify our own problems rather than having the press, the Congress, or other external organizations do this for us. That's one of the biggest problems we have in the Medicaid program - an annual scandal in just about every State. It always appears as if somebody is ripping us off, and we just didn't know about it. Nine times out of ten, there is already some action going on, vis-a-vis some of the really bad actors in the program, but we've got to improve our ability to identify problems and take action. That will result in a deterrent effect, and will reduce the incidence of those problems.

On a different front, we are also working to improve the delivery of preventive services to children. There are two aspects of our child health strategy I'd like to discuss - an administrative strategy and a legislative one.

Administratively, we're trying to use all the resources of HEW to identify, channel, and refer eligible children to those resources that can provide health care services. We're going to try to do a much better job in using the PHS clinics and programs. But, as far as I'm concerned, the existing law just isn't going to work. The EPSDT program is flawed. It's flawed from a system point of view, and it's one that I don't think can be corrected, short of legislation.

EPSDT doesn't provide sufficient incentives to States, providers or beneficiaries. It's focused on screening rather than on comprehensive care. It's much more process than outcome oriented. Yet, it's the law of the land and we have to live with it and enforce those provisions in the law.

I think that if we were to move to the CHAP approach, focusing on continuing care and providing financial incentives for States to bring more children into the program, we'd be able to do a better job of serving these needy children. Today, there is no incentive to reach out and bring more children into EPSDT since each additional child served generates more costs to the State.

CHAP also repeals the EPSDT penalty retroactively. If you're concerned about EPSDT, if you'd like to see your program work better, I urge you to contact your elected representatives in Congress. If there isn't any message from home, in my opinion, CHAP may not move, and we'll be stuck with EPSDT and a very gerry-rigged kind of a situation.

I'd also like to speak to another area of concern to you all - long term care. In the long term care area, we have a variety of things going on, but the bottom line is fairly simple. We really don't understand all of the problems associated with the incredible growth of long term care services. We really don't have a good handle on what the solutions are. We see a demographic and a sociological change in the population of the United States, and we're not sure how best to address these changes.

The elderly population is growing - particularly the frail elderly. We have a situation where parents no longer want to live with their children. Often, children no longer want to have their elderly parents around. We have a situation where the family ties and the way in which the frail elderly were once cared for just doesn't seem to be carrying through. The question we face, as a society, is what to do. To put it differently, how do we provide those services that this population legitimately needs? How do we provide them in a manner that is both cost effective and appropriate for these individuals?

Most of the aging individuals in our society don't need intensive long term care services - but most of the services available are acute medical services. In most cases, the acute medical model is inappropriate to the needs of this population.

By virtue of the way the Medicare law is written, the Federal government does not really address this demographic and sociological problem. The Medicare law is quite clear. It's an acute medical program. When an elderly or disabled individual is sick or is hurt, services are provided.

The Medicaid law is much more flexible, and as a result States have taken the brunt of the long term care responsibility. In many States, long term care has become a bigger dollar volume outlay than hospital costs. Clearly, if you look ahead, you will see that, for States, long term care is going to be the big dollar issue.

I'd like to tell you that we've got everything covered and that it's all going to work out. But I don't think there is -- either in the academic community, in the public policy process, or in many States -- an approach to these long term care issues that is viable either financially or from a service point of view. In fact, the Medicaid program's increasing long term care orientation may not be appropriate, given Congressional intent.

In many States, what we see is Title XX "capped", and good old Medicaid coming in and paying for services that are marginally appropriate under our law. To the degree that people are being helped, that's fine; but the question is can we keep this up and should we keep it up, over time?

We have a demonstration strategy this year to experiment with channeling people to the appropriate service long term care delivery provider. That could be a long term care institution, a home health agency, or some other kind of structure for providing, in some cases, social and, in other cases, health maintenance kinds of services.

Much of this has to do with inventing or developing new ways of keeping the elderly feeling productive, feeling vital, and not letting them get into situations where they need SNF or ICF care for an extended period of time. I think there have been some excellent successes in providing social services and support to this population and avoiding custodial care that may not be appropriate or effective in any other terms than extending life.

The basic problem remains, however, that we are trying to provide services through Medicare and Medicaid, which are medical model programs and really aren't appropriate. I think we've got to do a better job of identifying the appropriate role for the Federal government generally and for the Medicaid program particularly. We've established a long term care policy group within HCFA, that Deputy Administrator Earl Collier chairs, to take a look at the policy options for the next three to five years.

In planning for the future and in trying to meet current demands, we're striving to be as sensitive as we can to our impact on States. To achieve that goal, we must have more frequent contact with State representatives. We must have mechanisms for ongoing communications in general sessions and on specific issues as they arise.

As I have mentioned, on the CPT-4 issue we had a very strong indication from some of you that we shouldn't go ahead with what we originally intended, which was to mandate a single system for procedural coding. Maybe we didn't hear the message exactly right, so I think we need a mechanism for ongoing communication - one that can represent the views of most of the States.

We meet regularly with our fiscal intermediary group, with the carrier representative group, and with an array of technical advisory committees on Medicare issues. It's been a very effective way of dealing with some of those problems. We need a similar arrangement with the States.

We're getting advice from you on technical issues, but I think we need a broader group. We'll be contacting you soon with a proposal to expand those communication efforts into a regular, ongoing relationship. What is critical in that relationship is that you, as States, come to some conclusion as to how you can best be represented vis-a-vis many of the issues we have, and that we have a body that can speak to us on your behalf. I think it has worked out in the Carrier Representative Group (CRG) and the Fiscal Intermediary Group (FIG). I hope we can work it out with the States because, clearly, there have been some missed messages. Clearly, some of our attempts to be responsive to certain segments of the State Medicaid programs may have been viewed as unresponsive by the rest of you; and we may have, indeed, caused problems that could have been avoided.

At HCFA, we are trying to create an institution that can deal with the health care issues of the next decade. We want to simplify our programs and make them more consistent. By doing that in Medicare, Medicaid, and PSRO programs, we can increase and improve provider participation and, therefore, improve access for our beneficiaries. We believe we also can reduce costs and overhead.

Perhaps many of you have the feeling that the HCFA reorganization is an attempt to have Medicare take over Medicaid. That is not at all the case. We spend a lot of time internally talking about the two programs, where they differ, and why. They are different programs in law. There's no attempt to combine them.

In each of the programs, we have discovered better ways of doing business. It's our hope that, wherever we can, we take advantage of those better ways and have both programs profit.

We're trying to improve financing programs to help people who are depending on us. We're depending on you to be participants in that process, either as individual States or through the mechanism I described.

If you take a look at the financing programs over the last ten years, you will find that States have had a remarkably significant role in most of the innovative approaches to the critical problems we face - the rate-setting commissions, for instance, in terms of hospital cost containment. In many States, the MMIS contains some fantastic ideas that the Medicare program, and certainly the private insurance industry, could benefit from, such as third-party liability efforts, crossover claims, a variety of approaches to making our programs work better.

We will try to learn from you. We will try to be more flexible in terms of how we run our programs. We are at a very important time in our nation's history. This country is moving toward a national health care policy. We're moving toward a recognition that our health care delivery system, while it provides superb care, is in an economic sense, not working right.

Costs continue to go up at an incredible rate. What you hear in Washington and in Congress is that we're trying to get to a national health care policy in an era of limited resources. The old method for making national change occur -- which was to buy everybody out, so nobody gets hurt financially and the new guys get the new money -- isn't going to work, because we are rapidly running out of money.

If current trends continue, we're not going to be able to afford health care services for many of our beneficiaries. There are five States that are cutting Medicaid benefits. That's not a humane solution to the problems we face. There is no State that provides such a thorough and complete benefit package that all the poor in the State get all the care that they deserve as human beings.

We've got to take a leadership role. We've got to understand our responsibility. As the country moves toward a national policy, we must help shape it.

I would encourage you to become active participants, as individuals and as Medicaid directors, in that process; because the next two to five years are going to change the health care system as dramatically as it was changed in 1965. The health system must be changed because we won't be able to afford it five years from today.

These are the years that are critical. We're organized at HCFA in a functional mode, because we think that's the way the country is moving. We are not organized to exclude anyone. We're not organized to cause problems in our communications with States. We want to increase communication, but it is incumbent on you, if you want to participate in that national policy development, to make your voices heard and to deal with us on all the issues of concern to you.

We work, in the sense of our financing programs, with States, carriers, and intermediaries. Our relationships are changing on all of those fronts. They will change more dramatically in the years to come. I think if we work together, the change will be not only positive on behalf of the beneficiaries, but it will be positive in terms of our relationships in the work that we do together.

If we don't work together, the momentum will carry us all. Personally, I'd rather shape the future than be overtaken by it.

The Regulation Development Process

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MS. DUNN: I want to talk to you today about the regulation development process in HCFA. One of the results of our reorganization activity was the realization, that won't come as a surprise to you, that regulations are one of our basic functions, the basis for everything we do.

Without good regulations, we really cannot successfully carry out any of the functions that we have identified as part of HCFA's mission.

In HCFA, unlike many department agencies, regulation development is a line, rather than a staff, function. The reason for this is that we do not directly administer the Medicare and Medicaid programs. The States administer Medicaid. The Medicare program is administered by fiscal agents, intermediaries and carriers.

For us, regulations are the basic vehicle for defining and articulating our policies on eligibility, coverage, reimbursement, et cetera. They are also the basis on which we work with States and fiscal agents to administer the program.

They are also the basis on which we monitor program performance to see whether our objectives are being met. With that realization, we looked internally at our own regulation development process and found a number of problems. As a result, we have substantially redesigned our regulation development system and made a number of changes that I would like to highlight.

We identified four major factors that we believe are critical to a successful regulatory development process. First, we need a system to insure that regulatory objectives are tied to HCFA's programmatic goals and objectives.

Too often we find ourselves developing regulations independent of any general consensus within HCFA of what we are trying to achieve in the aggregate, or what we are trying to achieve at sublevels of our efforts.

We believe that our regulatory program must match our overall goals. We need to have a clear process for deciding what those regulations are going to be and how they will achieve certain objectives.

And, most importantly, we need a process for deciding in what priority we need to complete the regulations. I don't know whether you are aware of it, but HCFA produces some 120 to 130 regulations each year, either in proposed or final form. So, it is a very large part of our workload.

Previously, we had no way to identify those regulations which were the most important, those which were the least important, or what our overall regulatory agenda was.

Finally, we need a process for setting schedules based on those priorities.

We have implemented a new agenda-setting system with the following features; First, each fiscal year we will develop an annual regulatory agenda. The agenda will identify specific programmatic goals and objectives that we intend to achieve with our regulations.

The agenda is tied to our management control system which links regulatory, legislative, and administrative initiatives to an overall set of goals and objectives.

The agenda includes two things: First - regulations that are already underway, meaning that they have been approved by the Secretary for development; Second - new initiatives that we want to consider during the fiscal year. These initiatives will not have been approved yet by the Secretary. We will submit regulation proposals to the Secretary's office for each of these new initiatives to get approval, and then publish a summary of the regulation proposal in the Federal Register.

The regulation proposal is available to anyone who wants to see it. It's a fairly comprehensive document. It has been strengthened considerably. It has a very detailed work plan, and much more discussion about issues and alternatives that we plan to consider. For anyone who is particularly interested in a particular regulation, I think it can be a very valuable document.

Secondly, we have categorized all of the initiatives according to one of four priority categories, Class 1 priority being the highest. The four criteria that we use to categorize regulations are:

(1) Critical deadlines that have to be met, such as when the statute specifies a specific date that a new program has to be implemented, such as the rural health clinic legislation. Also, we get court orders that we need to respond to.

(2) The extent to which the regulation will meet certain program or administrative goals and objectives, such as reforming or controlling reimbursement.

(3) The extent of outside interest in the regulation, meaning pressure to regulate or pressure not to regulate, which we typically have for all of our regulations.

(4) What the consequence of delay or not issuing a regulation is, in terms of lost opportunities to deliver new services, to eliminate inequities, to enhance beneficiary access to services, et cetera.

We have also built in a mechanism for applying priority classifications to performance standards for the overall production of regulations, as well as the amount of time that we would generally like to spend on each major step in the regulatory process.

The end result of this is an agenda-setting process which produces the annual regulatory agenda, which I mentioned, also, a six-month calendar of commitments with specific schedules, and a monthly production target of regulations that we plan to do for the entire fiscal year.

So, for the first time, we have, in the aggregate, a reasonable plan for most of the regulations we plan to do in a fiscal year. Obviously, we won't be able to pick up everything because new things show up all the time.

In addition to the agenda-setting process, we identified another key factor that we think is really important, management control. We found we needed an ongoing management process to insure that the schedules that we set, once we set them, can be met.

This is another major problem that we have had. We found ourselves typically overcommitting, being too optimistic about what we could finish and when.

To achieve management control, we believed we needed a central control point in the Administrator's office, as well as in the key HCFA bureaus that produce regulations, to be responsible for regulation development.

To do this, the Administrator set up an Office of Regulations Management in his office. The Bureaus of Program Policy and Health Standards and Quality, that produce about 80% of the regulations, have also established central units to manage regulations.

Previously, regulation development was highly decentralized within the bureaus. There were some 130 or 140 people throughout the Agency developing regulations, which, naturally, minimized the amount of our control.

In addition to establishing central responsibility, we also strengthened the regulatory development process in terms of the regulation proposal. We now require a fairly detailed workplan for each regulation, which covers the key steps, including outside consultation and the major internal departmental steps that are required.

As I mentioned before, the regulation proposal is available as soon as we publish the Notice of Decision to Develop Regulations.

Finally, the Administrator and Deputy Administrator will be holding quarterly reviews with the bureaus and offices responsible for regulations, to see how successful we are in meeting the commitments that we have made.

The third key factor is that we need an ongoing process to make sure that we have really looked carefully at the major alternatives that are available to us, particularly as they affect cost and burden, before we decide to issue a regulation.

As many of you know, Executive Order 12-044, "Improving Government Regulation", sets requirements for a formal regulatory analysis when the cost of a regulation will exceed $100 million.

The Secretary has recently issued new procedures which require us to perform a formal regulatory analysis in several other situations. We now carry out a formal regulatory analysis when there will be cost reductions of over $100 million, where the difference between the high- and low-cost alternative is $100 million, when we think the costs might be over $100 million, and where there is major controversy.

We had already taken significant steps to strengthen that process well before the Secretary had issued the procedures. As I mentioned, we have strengthened the regulatory proposal process, and the Deputy Administrator is personally chairing internal, "issue meetings," before the Administrator even signs the regulatory proposal, in order to review the alternatives that we are considering, and to review our cost estimates.

There is one other thing I want to mention about the Secretary's new process. The Department now requires us to conduct for each regulation proposal, a threshold study, which is a rather intimidating term for doing a better cost estimate or burden estimate, before we begin developing a regulation.

So, we will be doing that for each regulation proposal for significant regulations. Most of our regulations are significant. However, even though we hope to do a better job on the front end of this process, we also hope that we will get better comments when we publish regulations because, frequently, the best cost data on impact comes from the public comment process.

The final factor that we identified as critical to our process is simply that we need to achieve and sustain a high rate of production in order to meet all of our commitments. I think a lot of people think that we sit around and dream up regulatory projects just for the heck of it, but, quite frankly, the demands that are placed on us by the Congress, the Secretary's office, by our own program evaluations that show that we have significant operational problems, result in a regulation agenda which, as I mentioned before, can result in the publication of well over 100 documents a year.

By my guess, in the last two years, in order to issue regulations on a timely basis for everything that we needed to do, we would have had to produce 15 regulations a month. That is quite a lot. We actually produced about eight, so we have been in the hole a little bit.

This year, of course, since we don't have new legislation, we are going to be able to gain a little speed. There will probably be new legislation the following year, so we will be hit again.

Public Law 95-142 alone required us to produce over 40 regulations.

The last point I want to make is that you are probably asking, well, this is all very nice, but what is it going to do for me? Well, just a few comments.

I think it is very important that we now have the ability to plan almost a year ahead for the regulatory initiatives that we want to fulfill. We now have a plan which orders regulations in priority, so that we know which ones are the most important, and which ones the least important. When we have unplanned outside things hitting us, we can adjust our regulation agenda.

That is important for you to know because we will make this information available to you so that you have as much advance notice about our plans as possible.

Secondly, our agenda is tied specifically to programmatic goals and objectives, so that there is some consensus within HCFA about where we are going, in general, with our regulations, and also, specifically, what results we intend to achieve. Hopefully, that will result in better proposed regulations and better final regulations.

Thirdly, we will spend a lot more time thinking through our regulations before we even decide to do them. Again, that should result in much better regulations.

As a final note, I would like to point out that the first product of our agenda-setting process is the semi-annual agenda of regulations, which will be published by the Department on December 15, 1979.

This version of the semi-annual agenda has considerably more information in it. Not only does it have a description of the regulations, but it has a chronology of what has happened to it before. In addition, it has more information about the significance of the regulation, and also has a schedule.

That agenda represents all of the regulations that we have approval from the Secretary to produce. It does not reflect those regulations, which we call "new initiatives," for which we do not yet have the Secretary's approval.

We will be sending our Fiscal Year 1980 agenda to the Secretary within the next few weeks, and hope to make it available soon thereafter, subject to the Secretary's approval.

Fiscal Year 1980 Regulations Agenda Priorities

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MR. BOUXSEIN: I want to discuss briefly some of the initiatives on the regulations agenda which I think will be of particular interest. I will talk about both those that we have in the Bureau of Program Policy, and a number of those in the Health Standards and Quality Bureau which Ed Kelly asked me to discuss.

Let me start off with one that is well along in development, the third-party liability regulation implementing Section 11 of the 1977 Anti-Fraud and Abuse Amendments. That provision authorized the States to require Medicaid applicants and beneficiaries, as a condition of eligibility, to assign to the State their rights to medical support payments and third-party liability payments.

Section 11 also authorized agreements with other agencies, including the State IV-D Agencies, to assist in payment collections, and provides for incentive payments out of the Federal share of the collections to other units of government that assist in collections.

We published a Notice of Proposed Rulemaking on this in August of 1978. Although we received a number of helpful comments, those comments did not lead us to believe any major overhaul was needed. The major concern of the States was about 1634 Agreements under which the Social Security Administration makes eligibility determinations on behalf of the State for those beneficiaries also eligible for SSI. We believe that has been worked out. SSA plans to amend its procedures in order to obtain that information for the States. State IV-D Agencies expressed concerns about the vulnerabilities to which they were subject, and I think that there have been clarifications and revisions that should give them some reassurance.

That regulation is now in the Office of the Secretary for clearance, and we expect it to be published in a few weeks.

As I continue, I will give some target dates. I must hedge a bit because what I am giving you is the dates regulations are expected to be released by the Department. As we go through the process explained by Jodi Dunn, we can get a better idea of when HCFA is going to do its work, including consultation with others inside and outside the Department. But at this point, it is hard to have a great deal of confidence in projections as to how rapidly a regulation will progress through the clearance process. So, I must hedge a little on my target dates.

The next regulation I want to mention is the Medicaid regulation on reimbursement of hearing aids and eyeglasses. We published a Notice of Proposed Rulemaking in May, 1979, and received a lot of comments.

The NPRM would have required the States to adopt either an acquisition cost or a buy and purchase plan, or some combination of the two. We received a number of comments that were strongly in favor and some that were strongly opposed.

A few States indicated interest in a couple of other innovative ideas, and we are exploring ways to accommodate them with more flexible regulation language.

The other major issues in the NPRM revolved around the requirements with respect to reimbursement for hearing aids, particularly the role of an audiologist in making the examination and determination regarding the beneficiary's need for a hearing aid.

There, again, we received diverse comments. The NPRM required a physician's examination, and if the physician recommended an audiologist examination, we would reimburse for the audiologist's examination. Some of the comments favored the mandatory audiologist examination across the board. Indeed, some of them said that they would prefer that to the physician examination. Others said we were giving the audiologist too big a role.

It will take us a while to evaluate those comments. A reasonable target date is probably late spring.

The next regulation I want to mention is one we are working hard and fast on now. It concerns termination of Federal financial participation (FFP) in a long term care facility found to be out of compliance with health and safety standards.

As you know, this is an issue that has been around for a good while. There was a 1972 Action Transmittal which was not entirely unambiguous, and has certainly not been consistently implemented around the country, particularly with respect to situations involving a court order or the varying State appeal procedures.

We completed a final rule earlier this year, which established minimum procedures that a State should undertake when deciding whether to terminate a long term care facility. However, in that final rule we did not deal with the issue of when to stop FFP. We did not do so because we decided that the prior NPRM had not dealt adequately with that issue, and had not fairly given the public an opportunity to comment.

We are, therefore, going to write another NPRM specifically on this issue which we hope to have published by early spring. We hope that when this aspect of the regulation is published in final it will substantially reduce the number of court injunctions because the courts found inadequacies in our procedures, not necessarily with our substantive standards. We believe that this will also reinforce and encourage the States in their enforcement efforts on standards of health and safety.

Our strategy will be to tie our FFP decision to the procedures in the final rule published earlier this year, rather than to have our decision on FFP mandated by whether or not there is a provider agreement in existence. In other words, it now seems that our decision is being determined by what the courts or by what the States might do with respect to a provider agreement. We want to turn that around and have the decision based on procedures which clearly define the point in the process at which Federal financial participation should be stopped. If it then appears that a provider agreement needs to be extended in order to effectuate that policy, we will do so. On the other hand, if we think the time has come to stop FFP, we will do so, notwithstanding the fact that someone might have extended the provider agreement.

The next regulation I would like to talk about is the addition of items and services subject to the lowest charge regulation. You will probably recall that last year we published a regulation which authorized the Administrator to determine that there were items or services which did not vary substantially in quality and were widely and consistently available at a given price, or a given cost, and then to make those items or services subject to that regulation to pay for them at a percentile of the array of costs that were previously being billed to us. At the same time, we published an initial list of items and services subject to that regulation. Some 12 laboratory tests, hospital beds, and wheelchairs were in that list.

In March of this year, we published a Notice proposing to add to that list a number of laboratory procedures and items of durable medical equipment, particularly home use of oxygen. We received, generally, favorable comments on that Notice. We also received some comments expressing general concerns regarding the impact the regulation might have on beneficiary accessibility to the items included in that listing.

We have decided to slow down a bit and evaluate experience with respect to those items on the initial list. When we are confident about the impact of the regulation, we will then make a decision whether or not to proceed with the additional items. If we do proceed, we hope to be able to publish a Final Notice sometime in the middle of the summer.

Another item which I know has been of concern to a number of States is reimbursement for personal care services. That is, the optional service under Medicaid of providing personal care in the beneficiary's home. A number of problems have arisen stemming largely from the requirement in the regulation that the service be prescribed by a physician, provided in accordance with a plan of care for the beneficiary, and furnished by a qualified individual under the supervision of a registered nurse. HEW construes this as encompassing personal services which are essentially medical in nature, and those additional services which are incident to, and intimately related to, the medical services, but not housekeeping and related chores.

Unfortunately, the regulation really isn't clear and does not answer a number of questions relating to the periodic reexamination of that beneficiary's plan of care, the nature of the supervision by the registered nurse, or the qualifications of the individual furnishing the care. It is clear that we need a Notice of Proposed Rulemaking that would try to clarify a number of these issues, and we will certainly want to call upon your expertise in helping us reach some kind of an equitable resolution. We are looking for a Notice of Proposed Rulemaking sometime in the late spring.

The next item is one of my favorites. It deals with the complicated and esoteric subject of deeming of income in 209(b) States.

We have litigation brought by the Gray Panthers challenging the rules in, I think, most of the 209(b) States. Under these rules, in making the Medicaid eligibility determination, the income of the noninstitutionalized spouse is attributed to the institutionalized beneficiary. This applies only in 209(b) States; statutory requirements under the SSI program are applied in non-209(b) States.

We argued against the Gray Panthers in the litigation on the grounds that rules for a 209(b) State could not be less restrictive than SSI rules, but that didn't go very far with the District Court. We have appealed the decision, but I cannot say how the case will come out.

Meanwhile, we are under court order to revise our regulations and have. The NPRM was signed by the Secretary last week and should appear in the Federal Register this week.

Another big area which I think will be of substantial interest to you is a change in our method of reimbursing rural health clinics. The present regulation uses an all-inclusive rate calculated by the Medicare carrier for the core rural health clinic services, and offers the States a number of options on how to reimburse for the additional services which are covered under Medicaid but not under Medicare. By its terms, that regulation terminates in March, when we will have to replace it with something else or extend it for a period of time to allow us to develop a new method. We are working hard and fast on a new method. Our goal is to have a simplified process, including a greatly simplified cost reporting methodology which would tie into the Public Health Service cost reporting needs.

We hope to be able to receive a reasonably complete cost report once every three years from a rural health clinic and use that to develop a national base rate applicable to rural health clinics with a few features, including regional adjustments for area wage differentials and the development of a lower rate for those clinics which are significantly below that national rate, in order to encourage them to stay low. These features would help to keep the regulation from having an onerous impact and penalizing clinics which are efficient.

In the years between the cost reports, we would use some economic indicator to update the national rate. There is still a good deal of work to be done on that. I suspect that we will be in need of some help during the comment period, and we will welcome your assistance.

We hope to publish an NPRM soon after the first of the year. It seems clear we will not publish a final rule before March, 1980, so the chances are we will extend the current reimbursement system.

The last regulation I want to talk about concerns family planning. A Notice of Proposed Rulemaking was published in August, 1979, the third NPRM on this subject in the last six years. As expected, we received voluminous comments, particularly regarding sterilization and abortions, most of which did not address the issue of how to treat sterilizations and abortions with regard to family planning. They, of course, also took issue with the Hyde amendment, statutory limitations and our regulatory procedures, which are designed to safeguard beneficiaries. As confused as this entire subject has become, we, nevertheless, are hoping to publish a final regulation sometime in the spring of 1980.

Let me turn, then, to some of the regulations on the agenda for which the Health Standards and Quality Bureau is responsible. The two major ones about which I suspect you are aware, are the conditions of participation for hospitals and the conditions of participation for SNFs and ICFs. HCFA has done a great deal of work on both of those regulations. There have been public hearings. There has been extensive consultation with consumer groups, with

the States, and with the provider groups. We are now trying to put the finishing touches on Notices of Proposed Rulemaking for both areas. Our goal is to make the standards and conditions of participation less oriented towards process and more oriented toward substantive standards and measurable output. This should give facilities more flexibility in determining how and when compliance is achieved. Hopefully, the revisions will also offer some flexibility in the life safety code area by providing alternatives that the National Bureau of Standards has developed on meeting objectives.

The conditions of participation for hospitals are due to go into the Secretary's office very soon, and should probably be published soon after the first of the year. The conditions of participation for SNFs and ICFs will probably be published later in the spring.

The next item Ed Kelly asked me to discuss is not yet on the HCFA regulations agenda. It concerns reassessment of the survey and certification procedures for both Medicaid and Medicare. Particularly if the NPRMs on conditions of participation go through, there will be a need for substantially changing the way the survey and certification process currently works, and establishing compatible Medicare and Medicaid procedures.

This project, though, is really at the very early stages of development, and it is going to require some time. HSQB is anticipating holding some public hearings because they think that the issues will be of widespread interest and possibly cause some controversy.

Another item on the HCFA regulations agenda is certification of long term care facilities with repeat deficiencies. The present regulation has a rather rigid rule regarding denial of certification for a facility when a survey shows noncompliance with a standard on which the facility was out of compliance during a prior survey. This is true irrespective of the nature or seriousness of the shortcoming relative to other deficiencies or other actions which the facility might have taken. To some of us, it seems a rule which is more vindictive in thrust than analytical, and one we want to revise, so that the facility is judged on the seriousness of the deficiency, not simply on whether it is the same deficiency that has shown up before. A more reasonable approach would be to focus on the consequences of the deficiency and the capability of the facility to come into compliance. In other words, a deficiency would be treated the same whether it was showing up for the first time or for the second time.

We are preparing a Notice of Proposed Rulemaking on that. We are taking the opportunity also to clean up some of the fairly challenging language in the current regulations, and hope to publish that sometime soon after the first of the year.

Another regulation in progress in HSQB deals with the costs chargeable to a long term care patient's funds. This is a provision in the 1977 Anti-Fraud and Abuse Ammendments. It grows out of a Congressional concern that some of the patients might be subject to facilities attempting to misuse their personal funds. In addition, the Congress asked us to clarify what items should be included in the routine services covered by per diem charges and what items the facility could legitimately charge for.

The Bureau of Program Policy and HSQB have been working together closely on this to try to define some general categories of items that should be included in the per diem, and others for which the facility should be able to charge, and also to provide a means for determining the reasonableness of the additional charges that the facility might make. I think we are progressing well on that one, and hope to have it out early in the next calendar year.

A closely related regulation, but one developed separately, is the regulation dealing with the safeguarding of patient funds. This was also in the 1977 amendments. It grew out of the same Congressional concern. On this one, we published a Notice of Proposed Rulemaking in 1978 and received extensive comments.

Another regulation we are working on deals with the effective date of provider agreements. We also published a Notice of Proposed Rulemaking for this one in 1978. This NPRM tried to clarify and resolve some inconsistent policies between Medicare and Medicaid as to when Federal payments can begin once a long term care facility has applied for Medicare and Medicaid participation during the time between application and survey, review and analysis, the certification decision, and so on. Medicare and Medicaid were establishing different certification dates for no legitimate reason. The comments that we received on the NPRM were very supportive and we should be able to publish that regulation reasonably soon.

The last regulation which I would like to call to your attention concerns the extension of PSRO review to ICFs. This was another provision of the 1977 amendments. It is another one for which we have published a Notice of Proposed Rulemaking. It deals with the Secretary's authority to determine that a State's review in an ICF was ineffective or, in the situation of a joint SNF-ICF, where the State is reviewing the ICF, and the PSRO is reviewing the SNF, to determine that the duplicative effort is inefficient, and the PSRO should assume review responsibility for both aspects of the long term care facility. A third situation is when the State asks the PSRO to assume review responsibility.

The comments were helpful, particularly with respect to clarifying the criteria for ineffectiveness and inefficiency, and for clarifying the review procedures for making the determination, and consulting with the States in making the determination.

That one, I think, we are getting pretty close to closure on. We have discused it with the Deputy Administrator, and I think we will be able to transmit it to the Secretary's office reasonably soon.

That completes the list of items which I thought would be of particular concern to you. There obviously are a lot of other items on our regulatory agenda. There are a lot of items which necessarily impact you because of the adoption of Medicare reimbursement policies in the Medicaid program.

There are other things which are not yet on the regulations agenda, but are beginning to flow from the rigorous process the Administrator has put into place requiring that we tie our regulatory activities to our goals and objectives.

So, I think, as Jodi Dunn mentioned, the regulatory agenda will be published. At that time,you will see exactly what we are up to, and your thoughts on whether those are the right things and on any other aspect of the agenda will be most welcome.

Questions?

Question: Could you elaborate on how you intend to get State input on the regulations? Have there been any discussions around that?

MR. BOUXSEIN: Yes, there have been discussions. We are always in something of a quandry about when and how to do it. Given the rather protracted time it takes to develop a regulation, people have often indicated that they would like to be in more towards the end than the beginning. At the beginning, ideas are still rather general subject to substantial refinement. More people indicate that they want to see things when they are fairly well refined. Most of the time, however, when we most need help is at the beginning. As the process moves nearer to the end, the logistical problems of obtaining input become enormous. On the other hand, there are some problems with early input because sometimes people in the Office of the Secretary feel uncomfortable about our getting comments from the outside before they have a good feel for what we are doing.

Clearly, it is a procedure which is not without its difficulties, but it is one that we find helpful.

I mentioned the protection of patient funds as an instance where you saved our bacon. There was another one which would have been even more embarrassing had you not been there, that was the NPRM we published defining residency for purposes of Medicaid eligibility, which a number of you wrote in on and pointed out quite accurately that we had made a serious mistake with respect to the AFDC population. The result was going to be exactly the opposite of our good intentions.

So, we know the value of it. Working out the mechanics is the problem. I don't have any real solution now, but it is something, I think, we need to keep talking about.

Question: Is there any activity concerning the transfer of property and resources as it pertains to eligibility?

MR. BOUXSEIN: We do not have anything on the regulations agenda. We are aware of that issue, and we have got some people in the Bureau of Program Policy who are looking at it. I can't give you a clear signal yet as to how that will come out, let alone when it will come out, but that is something that will probably go on the regulations agenda reasonably soon.

MQC Error Rates and Causes

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I want to cover five things with you. First, I want to spend some time going over what has now become part of the same ground that Mr. Schaeffer covered in relation to the Bureau of Quality Control's mission and function within HCFA. Second, I would like to talk about MQC; where we are, what the data configuration seems to be looking like, and share some of the statistics with you. Third, I would like to briefly talk about EPSDT - some of the options that we are considering in that area. Fourth, I want to touch on some of the activities we are involved in, in relationship to sanctions and fraud and abuse situations. Finally, fifth, I want to spend a little more time discussing what we hope to accomplish through our program validation effort.

In terms of the mission of the Bureau of Quality Control, time does not permit me to give a full-blown presentation. I do think, however, that I consider our mission to be somewhat unique in the organization. Mr. Schaeffer was talking about the tremendous amount of monies being spent by these programs. I think he also touched on the heritage of the Medicare and Medicaid programs, Medicare clearly having an insurance-oriented program heritage, Medicaid similarly situated in some respects - in the sense that they did adopt certain of the same kinds of principles - but also with a very heavy focus on social concerns.

The basic situation that emerged, however, was as the two programs went down their separate channels, they developed separate approaches, distinct policies, different policies, different attitudes, and different procedural processes.

I think the Bureau of Quality Control, in that environment, has a special responsibility. We within the organization are, in a certain sense, the only component without a vested interest in either of those two heritages. I consider that a unique responsibility. I consider it our job to assess, on behalf of HCFA, the heritage of policy and procedures on both sides of the house; and to provide independent advice as to the relative merits of the sometimes opposing strategic approaches to basic issues.

In addition, I think it is also our mission to reassess some of the underlying principles that have guided both programs. As we combine those programs, we see that the shape of our mission changes considerably. It changes considerably because of the very substantial amounts of money now involved. When you combine the two programs, you have new insights into exactly the dimensions of the kinds of responsibilities that we have.

For example, it now becomes clear we have become the primary source of the existence of many classes of providers; where we, in effect, provide upwards of 75% of the entire revenues that those institutions are receiving. That puts a different dimension on some of the fundamental policy approaches that we take with regard to reimbursement and other relationships we have with those providers. I think it is our role to be sensitive to those things and to ease out of the history of those relationships whether or not fundamentally different approaches are necessary.

In terms of the organization of the Bureau, I will simply indicate to you that we have, within the Bureau, the capability to do systems analysis, financial analysis, to operate systematic operational kinds of quality control programs, such as MQC, and finally, a program validation function which I will talk about a little bit later.

In point of fact, what we have here is all the baggage and all the wherewithal to be in a position, on behalf of HCFA, to provide early warning and also to be on top of problem situations as they occur.

Turning now to the MQC situation, we have come a long way in an extremely short period of time. Some States have done an absolutely tremendous job in terms of acquiring staff and going through the difficult process of getting the wherewithal to do the program. Many States have gone to the ultimate purpose of the MQC effort in terms of assessing what those data are telling them, and are doing an extremely effective job in corrective action planning.

I would like to mention some of the States that we think have done a real good job in that regard. I know there is debate as to whether or not anyone should do that in these kinds of situations; I think it is a good idea because I know that these people have worked hard and they are moving ahead quite vigorously in the corrective action phase.

Maryland has done a good job. Michigan, Illinois, Minnesota, Utah, California, and Nevada have all done good jobs in getting their programs up, running, and moving into the corrective action phase.

On the other end of the spectrum, however, we have some States that are a little less aggressive, and we are working diligently with them to try to bring this program up.

I would say the fact that we are spending billions of dollars, the fact that Congress is concerned about some sort of a systematic approach to monitoring, in a quality way, the effectiveness of the Medicaid program, means that these programs in MQC are going to be with us. They may not be exactly the same kind of program five, ten years downstream, but some program comparable to that is inevitable.

As you know, we have been pushing all of you to get your data in for the first three months of the base period. We have it in for almost all jurisdictions, but some jurisdictions don't have it in, or some of the data that we do have causes us some concern. Therefore, the data that we have spun out, we are considering very preliminary. This is the first three months of the base period, the first time the data has been run through the systems, the first trickle of information is coming in.

I will share with you some of those very gross statistics, on a national basis, cautioning you that they are not in any sense indicative of where we expect to be when we get all States in and when we get the program purified in certain areas.

The eligibility payment error rate on the national scene stands at 6%. The claims processing payment error rate is 4.5% and, believe it or not, the third-party liability error rate is .5%. Early returns seem to indicate that the MA stratum eligibility error rate vis-a-vis AFDC and SSI, is substantially higher, something in the neighborhood of 3 to 5 times higher.

Also, the claims processing error rates fluctuate considerably. The range of fluctuation gives us some concern in several respects. Either we are not getting all the claims identified, or there are some wide fluctuations in that CP error rate.

Obviously, the third-party liability error rate is extremely low; .5% is just, in our view, unbelievable. It is particularly unbelievable where we have done a project, for example, in the State of Washington and by virtue of interviewing patients, by getting access to exchange of data tapes between the carriers and the eligibility rolls of the State, we are experiencing a return of about 15% after the TPL State review and Federal re-review.

If, in those kinds of situations, we can get a 15% error rate, there is something wrong, and we are working with the Bureau of Program Operations diligently to get some better approaches to third-party liability. CP is also important to all of you, but TPL does represent an opportunity to make an investment that helps you and hurts nobody. Those are pure savings. Beneficiaries don't get hurt by that. They are pure savings and they are worth, we think, a very substantial investment.

We also have some data I will share with you in terms of the impact of the Federal re-reviews. Of the 48 States where we have Federal re-review data, in 23 States the rate went up as a result of the Federal re-review, in 12 States the rate went down, and in 13 States it remained approximately the same.

The problems that we have run into -- and we are attempting to address them -- I will merely touch on to make sure you are aware that we are aware and are trying to do something. One problem, the claims processing process of not counting technical errors, is very much on our minds and we have, I think, already gotten out communications that would attempt to cure that for the April-September period. We are doing a fix with regard to the base to ferret out or adjust the base data to take out the technical error component.

We are also doing a study of claims, eligible versus ineligible, for purposes of identifying an eligibility error rate. The advantage of that, of course, is that we have a better shot at making sure that we get all the claims by just doing a statistical sample of the claims that are paid in a particular period, for purposes of creating the universe and the sub-sample. This approach gives a much quicker return on the investment in terms of not having to wait a lengthy period to accumulate the claims.

Finally, with regard to MQC, I would merely like to indicate that we all recognize that that is just the first step. Some of you have already taken that first step, but it is the first step, and the ultimate purpose of this is to acquire the information, the insights that it provides, so we can all move forward with the Bureau of Program Operations to design and effectuate corrective action.

Let me just touch on EPSDT. Some of you have been indicating a need for clarification, specificity, in terms of what kinds of documentation will be necessary to support your EPSDT efforts. A manual has been drafted. We have already had input from States and we expect to publish it in December or early January.

We are evaluating the feasibility of an incremental or staggered approach to the penalty monitoring function, whereby we would select certain features, such as informing and then service delivery, bringing it on in a phased way so that when we start we would not necessarily go through the entire EPSDT penalty monitoring. Instead, we would select out those ingredients and then bring on extra or added ingredients for the next quarter, and perhaps by the third or the fourth quarter, doing all components of the monitoring schedule.

We are considering that as a possible option. It would give additional lead time to the States and we will be coordinating with you in that regard. I think we have already had some input from you on that point.

Mr. Schaeffer said the effective date is firm but we are considering, or at least evaluating the feasibility of bringing on the actual penalty function a little bit more downstream. We are talking to our lawyers about that.

All I will say in the sanction area is that we have got some very fundamental problems to address in that area, not the least of which is the historical focus that we have had in terms of achieving deterrence through criminal prosecutions. I think that there is a beginning of change in attitude about that, in terms of whether or not criminal prosecution is always the best deterrent, or whether or not a more appropriate deterrent is a sanction strategy that would penalize abusers financially and suspend or eliminate them from program participation, and then look for possible criminal prosecution. The problem there, of course, is that many of the lawyers feel that any efforts in that direction may compromise the feasibility or the viability of later criminal prosecution.

There are two schools of legal thought on that. However, the problem we have is that if we are going to wait until the ultimate decision as to whether or not somebody gets criminally prosecuted, very few cases ever mature to that point because of the capabilities of the system, and, secondly, the vulnerability that we are in, if we continue to do business with those organizations for long periods of time, spinning out the same amounts of Federal monies to them in a sort of "business as usual" relationship. I don't think that is a particularly desirable posture for the organization to be in. I think we have to take some fundamental reassessment of that process.

State Directors' Council Report

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Chairman
State Medicaid Directors' Council

MR. JOHNSON: This is our second mid-annual directors' meeting, and we are pleased that we are able to periodically assemble, to have the opportunity to meet with all of the major interested parties and, to discuss the changing Medicaid issues and problems and obtain new ideas.

We feel that, due to the HCFA reorganization, the communications we saw developing and solidifying have been disrupted. However, we look forward to a more structured kind of relationship with HCFA and the possibility of having quarterly meetings, as a minimum, with key HCFA staff and some selected State directors.

We also are always ready and have offered to provide ad hoc special assistance to HCFA. For those who are not familiar with that offer, we again wish to reaffirm that State directors and the people back in the trenches doing the work are ready, willing and able to have a partnership with their Federal counterparts and work with them in the issues and policies developmental stage, as well as in the preliminary and final stages.

In order to improve our communications with HCFA, we reorganized our committee structure. We will have six committees, instead of five.

The Perspectives Committee, chaired by Peter Bloomsburgh from Illinois, will relate to HCFA's Office of Legislation and Policy. Second, we have the Health Standards and Quality Committee, chaired by Dr. Emmett Greif from Texas. We also have a Quality Control Committee, without the program validation function, that will be handled by Tom Russo of New Jersey. He will relate to the quality control activities other than program validation. Steve Press from Connecticut, will serve as chairman of our Program Integrity Committee. He will handle fraud and abuse, Medicaid Fraud Control Units, the Inspector General's Office, plus program validation activities. The Program Operations Committee will be headed by Howard Stansberry of Oklahoma; we feel he can relate to HCFA's Program Operations Bureau. The Program Policy Committee, headed by Pennie Bjornstad of Iowa, will relate to HCFA's Program Policy Bureau.

We feel the realignment of our council committees will provide direct points of contact for any State input or assistance in developing regulations, plans processes, systems, et cetera. We hope States will take advantage of this offer.

Now, to address several other operating issues. At times we may seem to belabor certain things such as quality control or EPSDT processes. However, there still are problems with these Federal initiatives.

On EPSDT, we support a delay of the penalty imposition until April of 1980, and we recommend an incremental approach to monitoring the single State agency compliance with Federal regulations, starting after April of 1980. From the States' point of view, lead time is still needed to implement revised Federal regulations.

Quality Control - As a result of the Michel amendments, there are proposed Federal regulations. We support excluding claims processing and TPL from any quality control disallowance. However, we strongly suggest that HEW reevaluate, reconsider, or review other aspects of these proposed regulations. We feel that they are based on error-prone laws and regulations, and we really want States to take a look at the legal basis for those regulations.

We feel there are some technical errors, especially in relation to the comments of Senator Magnuson, in the Congressional Record of September 24, 1979. We apologize that the following comments are going to be very technical, but bear with us.

We feel that the regulations should not penalize States that have already shown some progress or achievement in the significant reduction of errors under quality control. Apparently, the revised regulations do not reflect such achievements.

Also, we recommend that the process for Federal re-reviews under quality control through the Regional Offices be standardized.

We feel that there is no recognition of States that have a high error-prone population.

We believe that HEW should come out of the woodwork and be liable for SSI errors. I think that Federal liability has been emphasized and suggested several times in the past.

Finally, we also recommend that some recognition be given to a State's good faith effort in taking corrective action once any reviews or re-reviews are completed.

The foregoing items are very technical and difficult to convey in a report like this.

We still feel that the EPSDT and quality control processes leave a lot to be desired. We are hopeful that the dialogue can be continued and somehow improve the final process.

As to State assessments, we favor having a one team visit, whether ten days or two weeks in length, preferably every two years, to conduct a program review of a State's Medicaid administration. The approach of having eight or ten separate teams visit throughout the year is very disruptive and disconcerting to State staff. Therefore, we hope our recommendation, which is unanimous, will be carefully considered.

We would rather have all the troops come and sit down, perform the review, and then exit and leave us to take our corrective action.

On regulations, we commend HCFA on its movement to revise and develop regulations to reflect outcome and not process situations. However, we still recommend allowing a minimum of six months lead time in regulations in order to implement what HCFA requires. We know HCFA may feel hamstrung, but a regulation cannot be issued saying that in two weeks or a month, or whatever, the State shall do thus and so.

We keep bringing this point to the surface and it does not seem to get through. We ask again that HCFA consider this matter because we need a minimum amount of lead time in order to make it happen.

Also, we see that HCFA is still issuing policy changes through some Action Transmittals. Again, HCFA has to put it in the Federal Register as proposed and final regulations. It really is not acceptable to have policy issued through an Action Transmittal.

We also are seeing some Action Transmittals being released with very short lead times for States to submit required reports to HEW offices. Again, we need realistic lead time. HCFA has to consider the logistics of printing and distributing Action Transmittals. If HCFA needs a report, they cannot pop it out and expect that States are going to turn around and be able to comply. HCFA should consider the time it takes to filter down and the time it takes States to gather the information on a realistic basis, and return it in the requested fashion.

MMIS Implementation - We generally support the Schweiker amendment to HR 3434, which would require States to have MMIS systems installed by June of 1980, or be subject to the 25% loss of FFP. However, we feel there should be exceptions for small States that are so small that it is not practical to put in the elaborate MMIS. We also suggest there be exemptions if there are any delays caused by HEW in approving processing contracts with fiscal agents. In other words, States are willing to try to comply, but we find there are major hurdles that we have to clear in just having the contract documents approved.

Fiscal agent, claim processing contracts, and the need for rebidding - We say that there should not be a policy or rule that would require periodic or set cycles for rebidding contracts. We recommend that consideration be given to a State that has a contractor performing at a level above norm with quality services being received on a cost-effective basis. These special factors should be considered before a State is requested or compelled to rebid, if HCFA currently has such authority, which is highly questionable.

Another item is nursing home reimbursement. We support retention of the present provisions of Section 249(b) on long term care cost related reimbursement. We contend it allows flexibility to the States to develop varied methods for reimbursement of these facilities. We oppose repealing it or making it open-ended. Section 249(b) is really one of the strongest pieces of legislation we have allowing States flexibility.

We want to reaffirm the need for extra FFP for certain operational costs. We say that 100% FFP for long term care certification is essential and should be continued indefinitely. Likewise, we have proposed that 90% FFP be available to the SUR State agency staff, in order to identify fraud cases that could be referred to the Section 17 units.

States keep dwelling on the FFP issue and you are probably saying, "That's all they ever think of - more Federal money." You should keep in perspective that State resources are rapidly and constantly shrinking and are being frozen. Even though programs are good, the ability of a State to obtain ten positions, or any positions, and the funding match, whether it's 10% or 25%, becomes a major factor in State budget processes. We want to indicate we are not just plumping for more FFP; it's because we cannot really obtain the resources in the State. Therefore, we need all of the leverage possible to make program changes and accomplish goals and objectives that both the Federal government and the States believe are necessary.

That, essentially, covers the major items we dealt with yesterday in our meeting.

We wish to thank HEW and their staff for arranging meetings such as this. We are hoping they can even be more frequent, especially with Committees or advisory groups, so that the Medicaid Directors can convey their recommendations on pressing issues.

We want to have open channels of communication with HCFA. We accept the challenge that has been cast to us by Mr. Schaeffer and Mrs. Tyssowski in stating they seek greater State input. They seem to be reaching out and opening doors. We want to reassure HCFA, as the doors are opened, they will find us standing there waiting to come in.

Panel: HCFA Questions and Answers

Deputy Administrator and Bureau Directors

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MR. HEIM: Good morning.

I am pleased to introduce my fellow panelists -- Earl Collier, Deputy Administrator of the Health Care Financing Administration, Dennis Fischer, Director of the Office of Financial Management Services, Peter Fox, Director of the Office of Policy Analysis, Peter Bouxsein, the Deputy Director of the Bureau of Program Policy, Jim Kaple, Director of the Office of Research, Demonstrations and Statistics, Ed Kelly, Deputy Director of the Health Standards and Quality Bureau, Mildred Tyssowski, the Director of our Bureau of Program Operations, and John Kennedy, Director of the Bureau of Quality Control.

We will take the questions that have been submitted in writing first, and we will go through all of these. I will state the question and then ask the appropriate member of the panel to respond.

I will pose the first question to Earl Collier. It says, "States feel that the HCFA reorganization may be a first step toward federalization of Medicaid. Would you comment, please? What are the next steps in this process and what are the legal bases for HCFA's reorganization activities?"

MR. COLLIER: Why don't I start backwards, first. I guess the feeling of the lawyers is that unless the Congress gives us a specific direction as to how to organize to accomplish a program, the agency delegated to accomplish the program can organize itself in the way it thinks best.

In the case of the programs we administer, Medicaid, Medicare, PSRO, etc., there are no specific directives as to the location within HEW of those programs or the way in which the organization has to be arranged.

Proceeding on that basis, we feel comfortable with our, quote, "legal bases" for organization.

Let me move back into the federalization question. I don't think that reorganization of HCFA reflected inside HEW or HCFA any views as to whether or not Medicaid will or will not be federalized. It would, of course, not be a matter within the discretion of the Administration, but rather a matter within the discretion of Congress.

My own view is that we're unlikely to see that happen, simply because Congress is unlikely to want, in the near term, to assume that financial responsibility. I think, as well, that there is a good deal of ambiguity in the country at the moment as to what directions to take concerning delivery of health care. All the debate about national health plans and so forth are exemplary of that ambiguity. My sense is that whatever happens, there will be a strong voice on behalf of State administration of some aspects of the program. So, I don't really think there's going to be federalization.

There is another question here: "States feel that HCFA will now deal with States as if they are comparable to Medicare carriers and intermediaries rather than as sovereign States. Comment. Explain when and how HCFA will relate to all States." There is a certain tipoff. You know, some of these questions are going along pretty well, and then some hooker is thrown in that leads you along the path that you think the writer wanted you to take, and, in this case, "sovereign States" is a little bit of a tipoff to me.

I will try to address the tension that the writer must feel in the air between HCFA and the States and between the Federal government and the sovereign States. I am lately from a State, and since I've learned most of what I know while in the State, I'm rather sympathetic to some of these issues that you have, and particularly to this one.

It is fair to say that HCFA will, increasingly, as best it is able to do, deal with its programs on a more business-like basis. That attitude will be brought to bear both on Medicare contractors and on States with respect to the business of these programs, the processing of claims, and various other aspects of administration.

To me, it doesn't seem feasible to take any other view towards them. Frankly, when I was in the State, and I was being pulled and tugged by various and sundry non-professional winds, I was always happy when I could come up on some Federal directive that would allow me to find a bit of civility with respect to the professional management of complicated and large programs. Every State should expect that as soon and as well as we are able, we will be addressing the machinery of the administration of these programs, as if they were important businesses. We'll try to bring a certain businesslike aspect to them. The easiest thing to point to is some of the work that we're doing in terms of the Medicare contracting and in terms of trying to make our contractors adhere to increasingly clearly-articulated standards for quality and timeliness of processing, and quality and timeliness of relationships to beneficiaries and providers.

We are going to have the same expectations with respect to the States. It is also true, for instance, if you look at survey and certification. Look at some of the problems we've had in Boston with the essential management, business-like management of an important program. We are going to try and deal with them in a somewhat improved manner. That, to me, is not a bad thing, and I don't think it should reflect negatively on the States.

The States may, in some respects, find it refreshing. Our attempts will be to simplify things, to try and put procedures and mechanisms in place that make us more comfortable with the administration of programs and less in need of monitoring, constant oversight, surveillance, etc.

To that extent yes, HCFA will now deal with the States as if they were comparable to carriers and intermediaries. On the other hand, the States and the localities contribute almost equally in terms of the money in Medicaid.

We are not now at a point where we see a need for uniformity in the way these programs are devised and adapted to the States themselves. Our sense is that we are prepared and well able to deal with the great deal of flexibility across the States in program design, and what-have-you.

There are certain kinds of things that would be nicer if they were uniform, but I recognize that the desire for uniformity is somewhat a desire for us to make our jobs easier. It is not a desire that should rule in the midst of every other competing interest here. We don't try to impose the same degree of uniformity in terms of the program substance as we do in the Medicare program which we expect to be uniform as to all the Medicare beneficiaries throughout the country.

As to when and how HCFA will relate to all States, we are doing that. The question might be better phrased, how can HCFA better relate to all the States? There has been, I gather, quite a bit of discussion this week about that topic. The presence of this panel here today, the presence of a number of our staff here these few days -- at what we regard as a fairly critical meeting, in terms of the evolution of the relationship between you and us in the administration of these programs -- speaks for itself.

We have a very great interest, on which we were willing to spend an awful lot of travel money this time around in communicating with the States as a group, to get input on issues of mutual interest. On issues of specific mutual interest (with respect, again, to States), I think most of you who have tried to reach us lately should be able to feel comfortable that the door has been opened. The door will be increasingly open.

We would hope to see a greater degree of formality in terms of the States' aggregation of their interests and in the way in which their interests are presented to us. We have seen that recently with respect to EPSDT.

MR. HEIM: Thank you, Mr. Collier.

I'll give the next question to John Kennedy.

"States need suggestions as to how and what to look for in detecting fraud and abuse in provider claims and recipient utilization and eligibility; also comment on the discrepancy and consequent disincentives for improved Medicaid referrals to Section 17 units, given the 75% FFP per State SURs units versus the 90% for Section 17 units."

MR. KENNEDY: The first question related to a perceived need for suggestions on how and what to look for in detecting fraud and abuse in provider claims and recipient utilization and eligibility.

I indicated to you earlier that we have, within the Bureau of Quality Control, a fledgling effort going in the area of system analysis. We are busily trying to come up with the systems approaches to precisely those questions.

Within approximately 30 days, we'll have fully brought up a MERS system, inhouse. We're hoping that some States will take the opportunity to share paid claims tapes with us. We can run them through our inhouse MERS and be in a position to give you a systematic analysis of what that MERS can do for you. We'll also provide you with the software, if your have SURS, to utilize those modules of MERS, to give you a better handle on potential abuse situations.

The packages that are included in what we hope to develop involve such esoteric things as "yoyoing", bringing the same patient back and forth to the same provider. We will have the systems package that will permit an analysis of that quarterly paid claims tape, to give insights into the existence or dimensions of "yoyoing"; and the same thing for "ping-ponging" - "ping-ponging" being the ricochet effect from one provider to another provider. And we'll also have a "gang visit" module. Also, there are too many evaluations, exceptional charge patterns, over-utilization, etc. -- about seven modules that we'll bring up, inhouse. We will be able to run them against your paid claims tape, and then feed the analyses back to you.

Hopefully, we would be able to convince you that there are definite advantages in bringing these kinds of systems into your operations, particularly those MMIS States with SURs capability.

Within the next few weeks, we will have HEWCAS, which is the audit agency software program. The difference between this and the MERS system is that the MERS is pre-programmed to get at the "ping-ponging", "yoyoing", etc., and HEWCAS is not. It is programmable for any particular surgical insight that you want to get, in any particular suspicious pattern; and we also would be able to do that for you. Once having done it, we should be in a position to share with you the software potential that you can adapt for your own uses.

On the Medicare contractor side, we have had a standard approach, for a long time, of doing some external auditing. We hope to convince the States to get into it in a more systematic way (efforts at external auditing). That means a sampling of paid situations, to go back on a questionnaire or other means of contacting the beneficiaries to find out if, in fact, those services were rendered.

I'm just mentioning a few of the things that we have going inhouse. It is important that we not send out forms and packages of programs, but that we get the people who are running those programs in the State to deal on a one-to-one basis with the people in HCFA who have run these systems and used your data. Thereby we can have much better dialogue and a much better insight into what can be done on a face-to-face basis. Then, based upon that, we should be able to provide software packages that would be translatable to other States as well.

The second question dealt with presumed disincentives, in terms of the higher match for the Section 17 units and the 75% match for the SURS. That's a difficult question, in theory. In practice, I think the simple answer is that incentive matching is a technique. Congress decided that that technique would be used for encouraging the establishment of Section 17 units. The theory was that once up and running, after a three-year period, they would have been so successful in convincing the States as to the potential payoff, both in terms of identified savings and deterrent, that would justify their own continuance after that three-year period.

A similar theory was used in encouraging States to get up MMIS systems where a higher match was contemplated. The theory was that, ultimately, the period of encouragement would get people into an MMIS environment where the matching would be ratcheted down.

Those are two instances of efforts at incentives to bring up these systems. Whether or not there are other things that should receive a similar incentive treatment is another question. Many people feel that there are any number of different things that should receive different treatment in relation to their functions.

Many would argue that certain quality control programs, that are cost-effective and can be demonstrated to be cost-effective, should be treated differently in the contractor as well as in the State community. That argument could be made. Section 17 got it, because Congress decided it was a good idea; and it is not inconsistent with a similar incentive approach that occurred with MMIS.

MR. HEIM: Thank you, John.

I will address the next question to Peter Bouxsein. "How can HCFA reconcile the encounter costs in rural health clinics with the allowed charges? Since in billing an encounter, the services will not be known, how can we compare to private practitioners' allowables for the same service?"

MR. BOUXSEIN: Frankly, I would appreciate a little clarification on the question. Could the person who asked this help me out?

Comment: An encounter or any visit -- a first grade class could come in and all the kids would line up and get an injection. That's an encounter and, of course, the State would be expected to pay the encounter cost. A rural health clinic could have a large number of encounters of very small services. When you go to get their retroactive adjustment, you've got to have it. You have no way of knowing whether you've got a laboratory technician there and how many people got blood counts, as far as I can tell. You have all the charges, grouped according to whether you put the salary of the lab tech in, what the supplies cost, but you won't know how many blood counts were done.

MR. BOUXSEIN: While the statute gives us considerable flexibility on reimbursing, it does direct us to look at cost. It is a cost-related calculation for the all-inclusive rate.

Comment: That's what I'm saying. You can have a lab tech there getting $12,000 a year and never do a lab test. You don't know. He's got a lab full of supplies. You paid for the supplies. He can throw them down the sink and order them again next year.

MR. BOUXSEIN: Well, there are some screens and upper limits that attempt to address that.

Question: How do you know a quantity of services, other than an encounter? Do you keep track of each blood count that is done when you go to do your audit for costs?

MR. BOUXSEIN: No, however, we are presently working on a revision to that regulation which would establish a prospective rate, without any retroactive reconciliation, which would again be based on cost.

MR. HEIM: The next question is for Peter Fox. "Any thoughts on changing the Medicare fee determination for physicians? Some think current methodology may contribute to inflation rather than being a cost-containment effort?"

MR. FOX: Last year we had a proposal that was part of the President's budget and legislative program to change the Medicare method of reimbursing physicians. The proposal has been dormant, through neglect and out of concern that it could politically interfere with the Administration's hospital cost-containment bill.

Right now, as I think all of you know, physicians are reimbursed under Medicare under a "usual, customary, reasonable" methodology. There is an upper limit that was set in the 1972 amendments that does begin to divorce the Medicare payment level from what physicians customarily charge. We've proposed moving to a fee schedule, which would be negotiated with the physician community and would allow us to do certain things such as redressing some of

the geographic imbalances now in the program, some of the specialty imbalances, and what we perceive as being biases in favor of high technology, procedural, surgical kinds of services and certain kinds of testing, as opposed to hands-on primary care.

At this point, the proposal is still being worked on. Where it will go from here, politically, I can't really tell you.

MR. HEIM: Thank you, Peter. Let's pass to Jim Kaple. "How can the process of seeking waivers of regulations or statutes be expedited? Sometimes, State pilot or demonstration projects are subject to time limits by State and authorizing legislation before starting the projects."

MR. KAPLE: We try very hard to expedite decisions on all grant, contract, and waiver applications. We particularly take waiver requests very seriously. They represent a significant amount of work on the part of the States. They represent, in terms of 1115 waivers, a willingness to commit funds to a demonstration activity.

It's important that you be aware of the process we go through in making a decision upon a waiver application. A number of procedural requirements must be met in the review and approval of a waiver. There are two closing dates annually for applications -- October and April. On those two closing dates, all applications for grants and waivers are competitively reviewed by an interdepartmental review panel.

There are usually two to 250 applications in each of those cycles. About 25% of those involve waivers. It takes two to three months to complete that review process.

Once the panel recommendations are forwarded, when a waiver is involved, there is concurrent review by the operating program and the Bureau of Program Policy. This also adds time to the process. By the time we are ready for a final decision on a waiver, it takes three to six months from the date of application.

Frequently, those applications do not contain sufficient information to make a final determination. Therefore, we have to go back to the source for clarification.

When you recognize all of these issues, you can see why it is very important that the applications come in a complete fashion and address all of the issues. Frequently the issue of protection of human subjects is overlooked.

If you are involved in assisting States in the development of applications, be sure they have thoroughly reviewed the application process. We have it all written out and will be glad to send you that kit on the application process.

Once we have thorough applications, the final decision usually takes three to six months.

There is a way to take an application out of cycle. It is rarely done. With the numbers of applications I just discussed, we should try not to do that any more often than is absolutely necessary. But, that process can be accelerated to the point where, within 60 to 90 days, a decision can be made.

That process is invoked, however, only one or two times a year in very extreme situations.

MR. HEIM: Thank you, Jim.

Let's pass it to Ed Kelly. "What, if any, plans are being made to combine IPR and MR reviews of long term care facilities with survey and certification?

MR. KELLY: At this time, 12 States have, to varying degrees, administratively and functionally integrated their survey and Medicaid Inspections of Care review (MR/IPR) functions under a single jurisdiction. This integration ranges from the combination of the survey team and Inspection of Care team into the same team that performs both functions to the placement of the survey agency and the Inspection of Care agency into the same organizational unit.

The Health Standards and Quality Bureau is participating in evaluations of integration projects in Texas, Massachusetts, and Wisconsin. These experiments are demonstrating that integration of survey and Inspection of Care functions can lead to more comprehensive evaluations of a facility's care and services, while reducing costs, principally in the area of travel.

We are planning to discuss this issue further in revisions of the context of Subpart S regulations. These are the regulations detailing actual policies and procedures for certifying facilities for participation in Medicare and Medicaid.

With these revisions will come a great deal of conversation, public hearings, and a Notice of Proposed Rulemaking. The integration of State survey and review activities will be one of the major issues discussed during the Subpart S hearings. There are no plans to do it immediately. Wherever we can be of help and share the experience of other States where they are doing it, we are available, but before a decision to do this, there would be a great deal of open discussion about it.

MR. HEIM: Thank you.

Let's move right down the line to Mildred Tyssowski. I am going to give you an easy one. "What's the latest on abortion?"

There's a second part to this. "I understand the continuing resolution eliminates the Category 2. Will this provision continue after November 31, 1979?"

MRS. TYSSOWSKI: What is the latest on abortions? I can say we had one definition to enforce for Fiscal Year 1979; we have another definition for October 1 through November 20, 1979, and what's going to happen after November 20th, no one knows.

We have heard that, once again, this is going to be raised as an issue that could considerably delay the enactment of HEW's Fiscal 1980 appropriation. The answer on Category 2 is yes; the definition for October 1 through November 20, 1979, does eliminate the category of severe and lasting physical health damage to the mother.

MR. HEIM: Thank you. Let's ask a related question, and this one is to Peter Bouxsein. "Why has HCFA refused to change regulations on hysterectomies as they affect women incapable of child-bearing?"

MR. BOUXSEIN: This is another neutrally-phrased question. Let me reassure you that we are not refusing to change that regulation. We are working hard and fast on it.

I will give you a little background on that regulation to provide enough context, so that you can understand why the development of a policy issue on something like this takes time.

There were two special features to the development of this regulation. One is that it is not a HCFA regulation, alone; it is also a PHS and a Human Development Services regulation. For that and other reasons, this regulation was developed by the Office of the Secretary. We had a chance to comment on the regulation as it went through clearance and during the comment period. I was in the Office of the General Counsel at the time, and Bill Fullerton (then the Deputy Director of HCFA) asked me to find out what policy concern was being addressed by this provision of the regulations and whether it should be changed.

I was advised that there were serious concerns about unnecessary hysterectomies throughout the country, and that there had been at least a few instances in which a woman had been given a hysterectomy and later indicated that she did not understand that she was going to be sterilized as a result. People who were developing the regulation in the Office of the Secretary decided to err on the side of protecting the beneficiary by requiring that they be fully informed in all cases of the consequences of hysterectomies.

That is why that regulation reads as it does. We have been working on this issue; but it may be difficult to reach consensus reasonably soon within the Department on what, if any, changes should be made. One alternative would be the deletion of hysterectomies entirely from that regulation. That may not be possible. Another alternative would be to establish some age limitation requiring acknowledgement only by those that age. I understand, however, that there is a difference of medical opinion as to what the age should be. It may be difficult to arrive at a consensus.

So, we are not refusing to do it. We have people working on it.

MR. HEIM: Thank you, Peter.

Mr. Collier, let me pose another question to you.

"Mr. Schaeffer referred to a HCFA long term care strategy and task force headed by you. Would you go into more detail?"

MR. COLLIER: "Task force" denotes probably a degree more of formality than there is, at the moment, but we expect to develop a more formal process within HCFA for examining long term care issues. I suppose that symbolically

represented in this room, in terms of State Medicaid programs and HCFA's own staff, is on the order of 90% of all the expertise there is in the world, or at least in this country, in terms of long term care delivery. It is not a subject on which there seems to be much academic expertise or training.

I would say we are a year or two away from the dam bursting on us. For better or worse, hospitals have consumed the interest of health professionals, over the years, not exclusively, but to a large extent. Things are changing and there's more emphasis, but I just don't believe that long term care has received the emphasis it deserves.

We have a number of immediate problems on the table. We had an embarrassing situation with the Congress on a report that had been requested in HR-3. We have some problems, dramatized by Senator Chiles, with fraud and abuse issues in the home health area.

We have a direction from Congress to spend $20 million on so-called channeling agency demonstrations next year and, indeed, a very explicit direction by Congress on the organizational arrangements that HEW should make internally for the spending of that money.

We have had recent press coverage in the Boston Globe about survey and certification problems. We've had a great deal of controversy about our proposed amendments to the conditions of participation. We have a lot of interest in and pressure on us with respect to boarding home, adult home situations. We have the 249 issues, both with respect to the Boren amendment and with respect to our own internal capacity to approve and monitor State plans submitted under 249. We also have the issue of the so-called 51% rule concerning institutions for the mentally diseased, the whole idea of deinstitutionalization and the housing in SNFs of patients whose primary diagnosis is mental disorder.

Those are just some that came to mind when I saw the question. It was a rather quick way of totaling up a list that involves hundreds of millions of dollars, maybe billions of dollars, lots and lots of beneficiaries, and a major societal problem.

We're spending approximately $7 billion on long term care delivery. You are spending not quite $4 billion. All of this is done in nearly 20,000 licensed SNFs or ICFs, and a number of home health situations.

There's a lot of information to be gained from that expenditure. I don't know that we've gained as much as we should. We have a number of demonstrations, evaluations, and studies underway. You have a lot. There are just enormous amounts of different things being done in the States using Title XX money as well as other resources.

Faced with these problems, we are trying, as systematically and as rapidly as we can, consistent with our own limited resources, to try to inventory the experience that we have gained and the experience that you've gained through all of our years of involvement in this area (both in terms of day-to-day line operations and experimental and demonstration programs and studies), so that we have some sense of the pathway to walk over the next few years.

To me, it is not satisfactory to talk global, philosophical terms about deinstitutionalization or finding alternatives to this or that. Those are four, five, six-year out issues, in many cases, at least in terms of a $10-plus billion expenditure. We have much more of a sense of incremental concerns than of what are we going to do next year. My feeling is that we haven't sufficiently canvassed where we are, in order to make judgments about where we should be next year.

Under Secretary Stark will be chairing a more formal task force than mine in HEW, to canvass the Department situation.

OMB has a staff at the moment that is doing the same thing for the President in terms of the Federal government's total involvement.

The problem in long term care is clearly one of coordination of the many different actors who have a financial and/or other interest in this. At HCFA, we are trying to do our own homework, so that we can do our part when it comes to the larger questions.

I think the States have the preponderance of the experience in the area. The real call here is for input from the States; not only through us but through the Title XX agencies in HEW, through HUD, through whomever you deal with at the State level. If you have an interest in our programs and in trying to help us get a sense of our own situation, I hope that you'll come forward.

There's a lot of information out there and a lot of insight.

We are looking forward to an intensive period now of aggregating the knowledge that we have,so that we can think more intelligently about the next few steps that we should take.

MR. HEIM: Thank you.

Let's pass to Dennis Fischer next. "Is the proposal for delay in paying letter of credit on a checks-issued basis authorized by legislation, regulation, or arbitrary HEW decision?"

MR. FISCHER: The Social Security Act permits the Secretary to determine how and when we shall reimburse the States. This new method of letter of credit is also consistent with the Treasury Department regulations and is the same method we use on the Medicare side. In both the Talmadge-Dole bill and the omnibus Medicaid-Medicare amendments, there is a provision that would mandate use of this method of letter of credit, before the end of Fiscal Year 1980. It's probably impossible to do it, but nonetheless, there's a good bit of legislative interest. I would characterize the interest not as substantive but as a quick financial gimmick to reduce, on a one-time basis, outlays; and that's the context in which it's been considered. That was the context in which we proposed this different method of channeling money to the States.

MR. HEIM: Thank you. The next one is for Peter Fox. "SSI legislation to prohibit transfer of assets is tied to welfare reform. Does HCFA have any technical amendments that may be more likely to be enacted?"

MR. FOX: The transfer of asset provisions are in two different bills. One is in the welfare reform bill and the other is in HR-934, the Talmadge bill.

The welfare reform bill mirrors the Administration's proposal, in that it would have a transfer of asset provision applied mandatorily to SSI, AFDC, and would bring in Medicaid.

HR-934 instead would allow, but not mandate, the States to have a transfer of asset provision specifically for Medicaid; it would not affect SSI. Some of the differences relate to committee jurisdiction issues. The other difference is that the transfer of asset period (the period during which the States would look back at the transfer of assets full market value) is two years in the welfare bill and one year in the Talmadge bill.

So, the answer is that it is being considered in two vehicles, either one of which has, in our view, a reasonable chance of passage.

MR. HEIM: Thank you, Peter.

Jim Kaple, "Any plan to evaluate the results of the new EPSDT regulation in terms of benefits to children, not just value of data?"

MR. KAPLE: Let me speak first to program evaluation, in general.

We are planning to devote additional resources and personnel to the whole program evaluation question. EPSDT specifically is one of the top two or three program areas that we will be evaluating in depth over the next two fiscal years. Any such evaluation looks at the total impact of the program, as well as the specific regulations which attend that program. So, the answer to the question is, yes, we will be evaluating EPSDT; and yes, we will be looking at the impact of those regulations as well as the impact on beneficiaries.

MR. HEIM: Thank you. Ed Kelly? Here we come with PSROs. "How should PSROs consider changes in level of care, SNF to ICF and vice-versa, in skilled-only and intermediate-only facilities? Can these be considered adverse determinations? Have PSROs been so advised?"

MR. KELLY: A change in level of care may or may not require a PSRO to issue an adverse determination. If a patient is at the SNF level of care, and the PSRO review coordinator determines that the criteria for SNF level of care are no longer met, the PSRO physician advisor must be contacted to review the care. If the physician advisor agrees that the patient no longer requires SNF level of care, the patient's attending physician must be given the opportunity to comment. If the attending physician agrees with the physician advisor's determination, the patient should be discharged from the level of care by the attending physician, and no adverse determination is issued. If, however, the attending physician disagrees with the physician advisor and refuses to discharge the patient, the PSRO must issue an adverse determination. In the case of a Medicaid patient in an ICF, the same process would apply.

A patient going from an ICF to SNF level of care is treated as any patient who is admitted to an insitution. This patient would be subject to admission review and would have to meet any other program requirements for admission.

MR. HEIM: Thank you. I'll address this question to Mrs. Tyssowski. This is in the form of a suggestion. It is "that consideration be given to 90/10 FFP for personnel costs and operating Medicaid management information systems for a three-year period after certification." Would you care to comment?

MRS. TYSSOWSKI: Perhaps an argument could be advanced for some additional time for 90% funding after certification. Three years, just on the surface, sounds like a long time; but we are willing to entertain the arguments or thoughts any person had in mind when they suggested this. I think it would take a legislative change to accomplish it.

MR. HEIM: Here is another question for you. "In the same detail in which the information is requested on Form 2028, please explain how HCFA plans to use that information."

MRS. TYSSOWSKI: Form 2028 is the Minimum Medicaid Data Set that we are now in the process of initiating. Actually, some features of this data set are new, such as data on claims processing, length of time for processing claims, and so forth. This will become the data base for establishing statistical standards that we've talked about in this conference.

Much of the data, however, relates to the amounts paid out in terms of vendor payments and the groups that are covered. This is very basic program information needed at a national level to be aggregated, to handle inquiries from the Congress, from various points in the Federal sector as well as outside. I'm sure a lot of the information is necessary for you to answer questions addressed to you in the environment in which you work. Also, a lot of this information will be used in various publications.

MR. HEIM: Let's go back to John Kennedy, and we'll give him two questions. The first is, "What is the likelihood that the October 1 EPSDT regulation implementation date will be extended?" The second is, "Give us an update on Project 500."

MR. KENNEDY: The answer to the first question is relatively short: it's very unlikely.

I don't know how many of you are familiar with Project 500. It subsequently became known as Project Integrity I.

This was one of the first concerted efforts by the Inspector General to take a targeted look at physicians and pharmacists. We began with identifying 25 of each in each State for in-depth assessment of their patterns of practice, using the HEWCAS and other statistical techniques.

I can share the results of that with you. We ultimately identified about 2,482 cases. I don't know whether these columns add up, but they should be approximately accurate. Of that group, 1,620 were closed out with no action. It was found that the preliminary indications didn't seem to prove out. Of 401, however, there were some administrative actions taken. They could have been sanctions, terminations, or overpayment recoveries. I believe there are some indications that that activity in relationship to those 401 cases perhaps involved somewhere in the neighborhood of $6 million of savings in overpayments.

In addition, 42 indictments were obtained, with 24 convictions and 3 acquittals. The remainder are still pending.

We still have 229 under active fraud investigation that we understand, through the Inspector General's office, are being pursued. We have a total of about 176 of those cases that are still pending potential administrative action, and we're still in the preliminary stage with regard to 14 cases.

Those are roughly the statistics and the data on where we are with respect to Project 500 or Program Integrity I. There was a report issued in February 1979, which detailed at some length the lessons learned from that entire project. It is a rather well-organized and well-presented discussion of that project and the lessons that can be learned from it. That document is available. We'll be glad to provide it to you, or you can get it directly from the Inspector General.

MR. HEIM: Thank you, John.

I direct the next question to Earl Collier. "HCFA talks about State-Federal partnership, but emphasis at this conference, and ongoing, is on HCFA priorities. What about State goals and priorities? States need to set their own directions. States have to drop everything to respond to Federal requests regarding lead time, manpower, and fiscal resources HCFA demands place on States."

MR. COLLIER: It's a tough world! And the pressures on all of us at the Federal and State levels in these programs are tremendous.

I'll go back to the point that I started with a while ago, and that is to say that our presence here is an indication of our hope that a fairly detailed and intense communication can be put in place.

It may well be that there has been a concentration at this conference on HCFA priorities and HCFA's agenda. I think we felt that that was a subject of some interest to the States. In a limited amount of time, you can only accomplish so much, and that was what we wanted to get done.

That does not, of course, mean that we have no interest in State priorities, objectives, or interests. My hope is that, through these conferences and lots of other vehicles, we'll have a chance to communicate back and forth in the true sense of that word.

The issue of States having to drop everything to respond to Federal requests is something about which we feel strongly, when we have to drop everything to respond to the requests made on us. It is a condition of life at all levels of government.

We will try to be more reasonable, in terms of the formal flow of requests and information. There will be times when pressure is on us. Most recently, in the context of the Michel amendment, we have had a tremendous amount of pressure on us. We were pleased to be able to share some of it with you. But you should not think that it was self-generated and that we were doing it just for arbitrary reasons of our own. We weren't. We were doing it because we were under -- and I emphasize -- "intense" pressure from the Congress, rightly or wrongly.

In the future, you should see a more systematic and orderly relationship being drawn, and I believe it will benefit both of us.

That is my short answer.

MR. HEIM: Here is a question addressed to each member of the panel. It says, "Mr. Schaeffer said Medicaid would not be subordinated due to the HCFA reorganization, but that HCFA would take the best of both Medicaid and Medicare. Would each panel member highlight how their HCFA office is looking at Medicaid to do this?"

MR. COLLIER: The issue that I addressed previously, I'll come back to. My strong feeling about this reorganization is that it is quite logical against the needs of the future.

The programs, of course, were organized before on the basis of the sources of the funds; to some extent reflecting the grafting of Medicaid onto the welfare concept and with a general appropriation, and the grafting of Medicare onto the social insurance programs, and the funds coming out of the health insurance and the social insurance trust funds. There was a preoccupation with the source and use of funds issues of those two disparate programs that doesn't make a whole lot of sense today. There are many things about those preoccupations that do make sense, but the separation of the Federal government's purchasing of health delivery services for a large portion of the population just made no sense.

We are now organized in a way in which our purchase of health services for citizens is going to be more cohesive and more coordinated, and we will carry over many of the concerns that existed in the programs before. However, I think we will graft onto those concerns a greater sensitivity to our role as a major purchaser of services.

We have some good lessons to learn from the tradition of the Social Security Administration which, as government enterprises go, has been a remarkably stable and business-like institution for many years; although it's had its ups and downs in this decade.

It's hard to run a business in government, in a government setting. It is hard to measure performance, when your output is not conditioned upon profit increase from one year to the next. It is very hard to manage a business when you have the kinds of mixed signals and mixed directions that you get from that great big board of directors on Capitol Hill.

I read something interesting yesterday about management, about the role of chief executive officers and top managers and the difficulties that they have with chopped-up calendars, telephone calls, crises, and inability to really focus at any length on anything. The author believed that the real role of a chief executive officer was to, in bits and pieces as best he could, inculcate a sense of values in an institutional ethos in the business in which they found themselves and which they were managing. The comment was that if you wanted to try and change those values, to evolve them, to crystallize them, or in any way to make a dent, you could expect that to take five to eight years, at a minimum. And, that was in a private sector business with all the kinds of hierarchical controls and management controls available there.

Well, if you think about that in the context of the government setting in which no HEW Secretary has ever served a full four-year term, and in which government officials, particularly at the appointive levels, come and go with some rapidity, it seems to me that you have a dramatization of the problem that we face in trying to run a great big business in an orderly way.

But I think that HCFA, through its present organization, has some opportunity to become a useful institution. Whether that will happen or not I think remains to be seen, quite frankly; but I think the opportunity is there, and my hope and my own sense of my own office is to try to help that along and make that happen.

If that happens, Medicaid and Medicare and every other program with which we are associated will benefit.

MR. HEIM: Dennis Fischer.

MR. FISCHER: Our office is responsible for the budget. Our impossible dream is to somehow get the Medicaid budget out of the Congressional realm, as the Medicare benefit budget is. You also can look at the checks paid-letter of credit, perhaps, as far as you're concerned, on the debit side, and say, "We've taken something out of Medicare and applied it to Medicaid." But we have little real interaction between the two in what we do. We're more an inhouse administrative function.

MR. HEIM: Peter Fox.

MR. FOX: My own office is really a very small one. I have roughly 11-12 professionals, of which 4 or 5, depending on how you count, are devoted to a combination of Medicaid and long term care isues. Long term care also relates Title XVIII, Title XX, and other areas, so that we have retained a direct Medicaid focus. There has been no internal reorganization in my office, as a consequence of the overall reorganization.

I'd also note that Peter Bloomsburgh, who has just been designated to represent you on legislation, and I have talked several times, within the last 24 hours, about developing better liaison on legislative matters. So, we would hope to work closely together there.

There are some areas where Medicaid has served as an example for Medicare. For example, we have been examining the Medicaid bulk purchasing arrangements to see whether they would make sense for incorporation into Medicare.

We are looking at various aspects of reimbursement to see whether and how they should be conformed. Most of the people on my staff do not come out of either a Medicare or Medicaid tradition, so that there is no sense in which one program is swallowing up the other.

We also, incidentally, work with the States in other areas besides Medicaid. For example, we have ongoing relations with the National Association of Insurance Commissioners, principally around the issue of regulating or otherwise affecting the sale of private insurance to supplement Medicare.

MR. HEIM: Here's another question, Peter. "Last year, the council proposed that HEW seek relief on the 100% requirement of physician certification and plan of care and legislative mandating of the one-third penalty for each facility where one patient is found out of compliance. What is the status of this? What rate proposals, if any, have been developed?"

MR. FOX: On the physician cert-recert, we proposed, as part of the Administration's Medicare Amendments (HR 4475), that cert-recert, as a requirement, be repealed and be strengthened with stronger plan of care requirements. These are not, at this point, in either the House or the Senate bills.

With regard to the 100%, we are looking at the possibility of a legislative amendment that would clarify the ability of the Secretary to set tolerance limits at something less than 100%.

So, we are very much aware of both of these issues.

MR. HEIM: Peter Bouxsein, would you comment on the general question of what your organization is doing to take the best of both Medicare and Medicaid?

MR. BOUXSEIN: Yes.

Let me speak first about our organizational structure and then about what's going on within the boxes that we've drawn.

There is only one place in our organization where we have made a distinction between Medicaid and Medicare, and that's in eligibility. Because of the distinctive statutory features of eligibility, we thought that it did not make sense, organizationally, to try to crunch those two together there. But in no other place in the Bureau of Program Policy have we drawn that distinction.

Obviously, there are some units within the Bureau that have more emphasis on Medicare issues and others that have more emphasis on Medicaid issues, but there is no instance in which there is not a continuous and concerted effort to achieve cross-fertilization of ideas and to bring experience in one program to bear on the other in innovative ways.

One of the things which helped was an intensive orientation program that Mary Kenesson and her staff put together after the reorganization which made it possible for all of our people to learn more about Medicare and Medicaid.

In all candor, the Medicaid staff that we inherited to create the new Bureau was a little short in terms of numbers, accumulated experience, and seniority. Through some foresight on the part of Henry Spiegelblatt in recruiting people and putting them through some intensive training before reorganization, we did acquire a Medicaid staff which has demonstrated ability at least on a par with the Medicare people who came to us.

There are a number of areas in particular where we are beginning to see some useful cross-fertilization. Two examples which come to mind are Bob Streimer's Division of Alternative Reimbursement Systems, and Sheila Ryan's Division of Medical Services Reimbursement.

I think there is a much greater awareness in the Division of Institutional Reimbursement which is, in large measure frankly, the former Division of Medicare Reimbursement. Frequently, in the past, we would get a proposal out of that division which dealt with Medicare reimbursement and we'd say, "What's the impact on Medicaid?" They'd say, "Well, gee, I don't know; why don't you ask the Medicaid people?" Well, that is no longer acceptable. That proposal goes right back with instructions to come forward with a more balanced analysis and presentation.

MR. HEIM: Peter, while you have the mike, another question: "On Integration Project No. 8,common XVIII and XIX SNF definitions, we were told the work product was going to the printer. What's the status?"

MR. BOUXSEIN: My understanding is that nothing was sent to the printer. This was passed along to the Bureau of Program Policy soon after the reorganization, with some slippage caused by the transfer.

I think the integration team found that it was a much larger and more complex project than they had initially anticipated. A set of draft guidelines was prepared at one point. As it underwent analysis, however, it became apparent that more extensive work was needed, so it's back in the analysis stage, and it seems highly likely that some regulatory initiatives will also be needed.

MR. HEIM: Thank you.

Jim Kaple, would you discuss what your organization is doing to take the best of both Medicaid and Medicare?

MR. KAPLE: In the research and demonstration area, I think there is considerable history already of looking to both the Medicare and Medicaid programs in our demonstration activities. For example, in the State rate-setting programs that we have supported over the years, both in their developmental and operational phases, we have encouraged and, in some cases, I think people would say we have mandated the participation of the Medicaid program in the development of those rate-setting capacities.

I can assure you, you will continue to see that kind of joint look at the Medicare and Medicaid programs in our R&D efforts. Let me highlight some areas where I think we are going to learn most from the Medicaid side. It's already been touched on earlier, and that's the long term care area. The majority of the experience with long term care and alternatives to institutional care is on the Medicaid side, and we'll definitely be looking very closely in that area.

I think another area where you will continue to see very real cooperation and coordination is in the area of data development and data mangement. We have several sites where we are doing joint, common billing demonstrations involving both the Medicare and Medicaid programs. As we look toward the implementation of common coding, common nomenclature systems and common procedural terminology, we will clearly be involving both programs and learning from the experience of both programs.

MR. HEIM: Ed Kelly, could you comment on the same question?

MR. KELLY: Our Bureau is basically a service Bureau to the two programs. Within HCFA, there are really two programs, Medicare and Medicaid. For some years now the conditions of participation that applied for hospitals under Medicare were the same used for Medicaid and in the long term care institutions, except for ICFs and the portions of institutions that are peculiar only to Medicaid, or in some cases in the ESRD program, peculiar only to Medicare.

That will continue. Our budget comes out of the other two budgets. Our purpose is to ensure proper health care for patients, and to ensure that the facilities they are in are proper. We do this for both programs.

MR. HEIM: Mrs. Tyssowski, would you comment on the same question?

MRS. TYSSOWSKI: First, I would like to answer in a rather general sense. The Bureau of Program Operations does have a large segment of the former Medicaid Bureau, as well as the former Medicare Bureau. As people with different backgrounds work to find the best resolution of an issue, I hope they will pick the best solution. It may be that the Medicaid way will be the best in the particular problem-solving issue they are addressing, or it might be Medicare. So, I think it's the side by side working of the analysts in our offices that will pick up the best of both programs.

But, to that, we will need help from the States. You know that Mary Kenesson issues publications on best practices in both programs. I'd like to have the people on my staff say, "Maybe we should do it the way Missouri does it".

As to specifics: Medicare, Part A and Part B, are often referred to as an accident of legislation. In time, we will be merging those Parts A and B of Medicare, and to some extent Medicaid has already been operating in a merged sense. I'm sure there is much we can learn as we move to merge A and B claims processing, and the data files necessary for such a merged Medcicare operation.

So, I think that's an example. Also, I think States may be doing more in the area of medical necessity and utilization review than what we've done in Medicare.

We've all learned a lot about competitive procurement and the development of RFPs. I'm sure that there are elements from some of the work by the States that can be combined with whatever experience we've gained in Medicare.

MR. HEIM: Here is a suggestion and a question: "Title XVIII intermediaries and Title XIX Medicaid agencies should coordinate their activities prior to requiring a provider to complete new claims forms or other changes that could have impact on both programs. Could this be formalized by HCFA?"

MRS. TYSSOWSKI: That's a good suggestion. We have talked about common physician's claims forms and adopting a common form for institutions to use. That would require, for the Medicaid program, the issuance of a regulation. It can be mandated without regulation in the Medicare program. In fact, we do have a uniform form for Medicare.

However, before we reach the stage of mandating something on a national level, if that is desirable, we should review the efforts going on in individual States. For example, in the Dallas region, many of the States are using the AMA physician claims form. Such efforts should be promoted. I think the regional office is perhaps the best HCFA organization to coordinate that activity.

MR. HEIM: John Kennedy, do you want to comment on the general question of what your organization is doing to take the best out of both programs?

MR. KENNEDY: The Bureau of Quality Control finds itself in a very unique situation. We have some operational responsibilities with respect to programs that are uniquely Medicare and uniquely Medicaid -- for example, MQC; Part A, QAP; and Part B, end of line. While the Bureau is dedicated to those two

Bureau lines in an operational quality control sense, it provides the operational setting for capitalizing on the experiences of the two sides of the house.

We're already doing that in some respects. I don't want to get too specific, but on the negative side, if you want to look at it that way, we are looking very closely at claims processing, in the sense that we want to not make the same mistakes that were made in Medicare, because we did make those kinds of technical errors. We're now almost reliving that experience, and we don't want to do that. We have already looked at it and are capitalizing on certain negative experiences on the Medicare side, in addressing the issue of claims processing in the MQC environment.

Inasmuch as MQC has addressed the inpatient population with respect to its claims review function, we are looking very closely at possibly some institutionalized quality control programs on the inpatient side with respect to the Medicare environment. In that sense, we are crossing over from the Medicaid experience into the Medicare side.

Within the Bureau of Quality Control, I feel a special obligation, inasmuch as we have no vested interest in either of those Medicare-Medicaid heritages, to look very closely at the history, the experience, and the attitudes, on fundamental policies on both sides of the house.

On the one hand, we have the advantage of a very wide range of experiences with Medicaid, in very different and many times unique situations, that I think puts us in an ideal position. On the Medicare side, it has been always necessary to approach policy issues on a much broader and more comprehensive basis that, inherently, makes it somewhat difficult; because once you start talking about a national program, the vested interests rise up in unison. So the degrees of flexibility that many of you in the States have had to deal with specific issues is something that we in the Bureau of Quality Control not only recognize intuitively, but want to take a very extra special measure of effort to look into. When we get into situations of fundamental policy options, we want to make sure that the national perspective that typically drives the Medicare orientation to issues is tempered by the experience in a more selected and narrow environment. The Medicaid program has that advantage. And I think it's a definite advantage.

In terms of our input, our advice and guidance, which we hope to provide, we also want to make a very special effort to tap that resource in as consistent and as predictable a way as possible.

MR. HEIM: Thank you, John.

I suspect that at some time in the future there will be a meeting similar to this with Medicare intermediaries and carriers. I will ask to appear on a similar panel, as a member, to say that Medicare would not be subordinated to Medicaid because of the reorganization, and to say what I was doing as the Director of Intergovernmental Affairs to assure that the best of Medicare was being taken.

I think we see the pressures and the questions arising on both sides, but let me just respond. I think Mr. Schaeffer, in bringing about the reorganization, was very conscious of the States' concerns reflected by this question. I think, in large part, this is why he did set up the Office of Intergovern-

mental Affairs, which he asked me to head, to be a point of contact for States and local governments for questions about who to deal with within the reorganized HCFA, or to assist States and local governments when they are dissatisfied with the answers or the responsiveness with which their questions are being addressed.

I think, as the reorganization continues to unfold, and meetings, such as this occur where you've had the opportunity to meet most of the Heath Care Financing Administration Senior Staff, questions such as this will recede.

Seminar Summary Reports

Key Issues/Points Discussed

HEW plans to approach its Child Health Strategy administratively by:

- o Increasing EPSDT population, expanding availability of services to all children;
- o Expanding outreach activity and broadening the application of the 75% matching resource for outreach services;
- o Coordinating with and utilizing HEW program and the American Academy of Pediatrics to identify problems/ solutions at the service delivery level;
- o Developing case management system for Public Health Service interface and general systems design for case management.

Legislative approach to Child Health Strategy includes revision to the Child Health Assurance Program (CHAP) proposal by:

- o Setting performance standards;
- o Extending benefits, expanding eligibility;
- o . Allowing coverage for eligible pregnant women up to 60 days after delivery;
- o Requiring direct dental referral and specifies the types of providers to be utilized;
- o Eliminating the current penalty provision and providing for increased FFP when certain performance levels are met.

States' Concerns/Questions

Utilization of schools to identify Medicaid recipients to classmates and teachers would be in violation of their privacy?

Suggested Response: Go into schools with high Medicaid population and screen all the children.

Central Office Response: Current confidentiality regulations are being studied with Office of General Counsel.

Responses to States' Questions

Secretary is considering request to extend implementation date for EPSDT penalty regulations, awaiting comments from APWA and HEW agency heads.

No action is being contemplated for development of a model RFP for EPSDT case management systems.

Under CHAP:
(a) Orthodontics is not mandated;
(b) No estimates of the added administrative costs to State Medicaid Agencies; and
(c) No age limit on pregnant women.

Administration basically supportive of the House version of CHAP, but has concern with costly added features.

Quarterly assessment status report is being reviewed by OMB.

Penalty assessment review manual should be completed by the first of the year; pilot test to be conducted in spring of 1980 using methodology in review manual.

Unresolved Issues

Revised policy on confidentiality.

Recorder: E. Ronald Niswander
Supervisory Medical Services Program Specialist
Medicaid Regional Office/Region IV
HCFA
Atlanta, Georgia

Key Issues/Points Discussed

Accelerating health care costs cannot remain unchecked.

No total agreement on appropriate approaches to accelerating health care costs.

States with rate-setting commission show decreased costs of services.

Some States using recipient control and provider participation in management showed cost saving features.

Most emphases on nursing homes and skilled nursing facilities.

Impossible now to second guess legislative actions.

Expect universal support for cost containment bills which treat providers equitably.

Some voluntary and some mandatory provisions favored.

States' Concerns/Questions

Expertise of policy-makers questioned.

Need for people involved to have fiscal management/hospital administration background.

Role of courts viewed as double edged sword; helpful when dealing with insurance companies/controversial when making public policy.

States recommend using State funded program areas as test before trying issues involving Federal Financial Participation (FFP).

Concern that accelerating Medicaid budgets infringe on States' other budget needs, particularly Education and AFDC.

Balance between liberal private health industry views and more austere taxpayer approach planned.

HMOs and more effective utilization review as cost saving devices.

Need for shared effort nationally and locally.

Federal Concerns/Questions

State flexibility and expertise in dealing with the problems untapped.

"Control not chance" pushed for by Feds.

Participants view data from Medicaid Management Information System (MMIS) as tool for program scrutiny.

More seeming conflict between cutting costs and still providing needed services for the poor.

Additional Comments

Medicaid program should fill health education role for providers, legislators and community.

Hope expressed that the cost of effecting a cost containment program would be analyzed.

Recorder: Jeannette Ann Mahoney
Chief
Non-Institutional Services Branch
Division of Provider Services
Coverage Policy
Office of Coverage Policy
Bureau of Program Policy/HCFA
Baltimore, Maryland

Key Issues/Points Discussed

HCFA controls 50 million dollars in Federal monies for demonstration and evaluation with waiver authority which additionally leverages hundreds of millions.

Ten areas established by HCFA for R&D priorities have been revised, but contain basically the same areas, i.e., Hospital Cost Containment, State Rate-Setting, Long Term Care, Risk-Sharing, and Risk-Shifting.

HCFA has additional developmental plans for integrated data systems and management information systems.

Uniform Hospital Cost Reporting System, out for proposed rule-making in about three months; target implementation late 1980.

Two State representatives from New York and Massachusetts discussed the R&D projects currently underway in their respective States.

- o New York Commission: Responsible for rate-setting, certificate of need and licensure.
  - Operational data base includes four data elements; uniform bill, uniform discharge abstract, uniform cost report and statistical report.
  - Expecting to initiate a 41 hospital payment experiment with other experiments anticipated in the areas of budget reviews and revenue caps.
- o Massachusetts Rate-Setting Commission; 1976, Massachusetts enacted permanent legislation on rate-setting

Utilization techniques such as volume corridors used to get all payors into the system. The advantage of this would facilitate a more direct management dialogue with hospital trustees in rate-setting.

The HCFA experience and expertise gained in previous States could be valuable resource in aiding States in developing and gaining passage of legislative proposals.

States' Concerns/Questions

What is the effect of rate-setting on HMO initiatives?

State Response:

A HMO is like any other entity; it purchases a day of stay. HMO or IPA makes revenue on length of stay.

Federal Response:

HCFA has no policy limiting alternate HMO or IPA rate-setting. May be situations where a differential is approved.

Federal Concerns/Questions

It was indicated that the Federal and State working relationships had been very good and produced in many cases a greater result than had been expected.

The Office of Research, Demonstrations and Statistics urges States considering any form of cost containment contact that office.

Recorder: William L. Bake
Program Analyst
Division of Operations
Office of Program Administration
Bureau of Program Operations
HCFA
Baltimore, Maryland

Key Issues/Points Discussed

Carter National Health Plan, as proposed would:

- Have States sharing in a limited way the cost of providing Health Care to low income beneficiaries;
- Have States determine eligibility for low income beneficiaries;
- Provide 1.2 billion dollar fiscal relief for States and localities in initial year;
- Allow 90% matching rate of the current State matching rate as of September 1979; and
- Include a residual Medical Assistance program that would cover mandatory services (such as Long Term Care), and optional services. Financing and administration of residual program would remain the same.

States' Concerns/Questions

What happens if no physician in an area will accept the fee schedule?

Will Congress buy such a large increase in Federal expenditures?

If a service is not medically necessary, how will that medical expenditure be counted towards the cost sharing in determining eligibility?

How will the resolution of payment of claims be handled for those services which could be covered under Health Care and the residual MA program?

Federal Concerns/Questions

How to get the perspectives on the bill so they can be brought to the attention of the committee.

Recorder: Linda Stella
Program Analyst
Corrective Action Projects Division
Medicaid/Medicare Management Institute
Bureau of Program Operations
HCFA
Baltimore, Maryland

Key Issues/Points Discussed

The discussion focused on management information and how it can be used for improving management at both the State and Federal levels. Both HCFA and State staff discussed the use of data for program management. Other subjects included:

- Update on implementation of HCFA's Medicaid Minimum Data Set (MMDS);
- Using Surveillance and Utilization Review Subsystem (SURS)-II Reports for program management;
- Use of MMIS to monitor trends in cost; and
- Effective use of Management and Administrative Reporting Subsystem (MARS) Reports.

States' Concerns/Questions

States generally agreed that it is important to know how SURS will be used before generating reports. States need to be able to determine their strategies, i.e, is SURS used for controlling fraud and abuse, delineating areas of education for providers and recipients, etc.

Strategies for using SURS for program management and cost containment:

- SURS data can be used for program management, e.g., from hospital cost containment to generating recipient profiles;
- Current SURS reporting generates excess paper, which can be reduced by using SURS in more of an exception reporting mode.
- Effectively designed, SURS can be used for provider profiling, determining provider costs, checking benefits furnished and recipients eligibility; and
- HCFA should develop a national strategy for use of SURS.

Several attendees noted that MARS does not answer management questions. Computer generated MARS reports are not appropriate for management use; however, MARS-produced data, when supplemented with appropriate analyses, can be very useful in management decision making.

Discussion of how analysis of MARS information can relate increases in program costs to increased costs of hospital stays as opposed to increased numbers of days. Important factor causing increase in costs is the increase in the quantity of services supplied. It was generally agreed that ancillary services are the primary cause of these increases. Such information can be useful for a States' hospital cost containment efforts.

Federal Concerns/Questions

Concern with management information practices. The mechanisms by which HCFA obtains management information and States' reporting, in part, centers around the MMDS. HCFA plans, during the coming year, to provide, through a contractor, technical assistance on MMDS. A series of four Regional meetings will be held for State staff to discuss management information requirements of both States and HCFA. The first meeting will be held in Denver, Colorado, in December, 1979.

HCFA Central Office will develop a data base information system with electronic transmission capability for HCFA use. HCFA's goal is to improve the level of Federal reporting, without increasing the flow of paper.

Recorder: Richard W. Moss
Acting Chief
Systems Planning Branch
Division of Systems Planning
and Development
Office of Methods and Systems
Bureau of Program Operations
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Key Issues/Points Discussed

Current Status: To date, common coding systems have been implemented for only a "few services" provided under Medicaid and Medicare. It is expected, during the next 12 to 24 months, systems will be in place for most of the services provided by both programs. Currently operational instructions call for the ICD-9-CM system to be implemented for diagnostic coding in all settings. A procedure coding system based upon CPT-4 is in the final stages of development. It is presently being tested in South Carolina. Also under consideration, for the near future, is the possibility of adapting the CPT-4 system for use with the provision of durable medical equipment and supplies.

Subject to resolving certain unresolved issues that could impact the purpose of common coding systems and related program management/administrative mechanisms, it is expected that the future course of action will include: (1) publication of a notice of intent to change existing regulations; (2) review and evaluation of comments; (3) publication of proposed regulations; (4) review and evaluation of comments; and (5) publication of final regulations. A date by which the foregoing would be accomplished was not indicated.

States' Concerns/Questions

Should codes be placed on claims forms by providers? Yes, even though some will have to be corrected.

Is the American Medical Association involved in converting interim codes assigned by carriers, intermediaries, State agencies, and fiscal agents to permanent codes? No, permanent codes will be developed by the HCFA Central Office. However, during the conversion phase, HCFA will maintain ongoing coordination with the American Medical Association.

Will the States be required to reimburse providers in the same amounts as Medicare? No, States will, however, be able to use some of the codes to establish levels of reimbursement.

Unless there is total cooperation by everyone, the implementation of a common coding system will not be accomplished.

Delays in developing permanent codes will give rise to problems in coding and reporting.

If physicians and other providers are required to purchase the coding manuals ($35.00 ICD-9-CM and $12.00 CPT-4), this could impede achieving total cooperation by everyone.

Any delay in distribution of changes to the codes will give rise to problems. Effort should be made to make certain that everyone involved with Medicaid and Medicare receive such changes on a timely basis.

Training is important. Effort should be made as quickly as possible to provide staff with training in working with the common coding system.

Federal Concerns/Questions

In order to make certain that a common coding system will work as planned, it will be necessary to make certain that the present codes used by carriers, intermediaries and fiscal agents will have to be converted to a common coding terminology. How to accomplish this with a minimal amount of interruption to daily operations is being looked into.

Currently being studied is which codes to use for diagnoses in ambulatory care settings. This is a critical issue that will have to be resolved.

The issue of whether to use 4 or 5 positions in coding diagnosis has already been discussed. A decision will be forthcoming. Until this is done, there is agreement that implementation of a common coding system for Medicaid and Medicare could be impeded.

There is question on how to implement systems that meet Medicare records requirements, as well as requirements regarding claims processing and reporting. Decisions will have to be made concerning these issues.

Unresolved Issues

The number of digits used in coding diagnosis is of particular concern. It was identified that this difference will have to be resolved before there can be total implementation of a common coding system for all Medicaid and Medicare services. Basic to this difference is that when more digits are used for purpose of coding, or when systems differ in the number of digits used, this tends to increase the possibility of errors, sometimes more errors than can be coped with. Further, differences in digit counts could preclude the integration of common data from one system to another.

Coding of similar services provided under different patient care settings. Coding differences could cause problems when patient population shifts between different levels of care. The feasability of using the same coding terminology for identical services is being studied. A decision is expected in the not too distant future.

Time required to design forms, prepare manuals and related guidelines, develop appropriate soft ware, and design/provide training for persons involved with common coding systems is contingent on finalizing the codes.

Another problem that will have to be dealt with is the impact on States' programs during the "conversion" phase. Where States have working relationships with fiscal agents, carriers, intermediaries and other contractors, "arrangements" will have to be designed for the latter groups effecting appropriate change. Unless there is total coordination between all involved groups regarding Medicaid and Medicare, implementation of a common coding system with a measurable degree of success will not be achieved.

How far back States will have to go in converting its data is being studied. It is recognized that States' working files vary from State to State. A decision will be made in the near future if States will have to convert only their current working files, or also include their history files. At the same time, consideration is being given to how far back HCFA will "convert" its files. HCFA recognizes that there must be total coordination between the Federal and State levels of program management if a common coding system is to be effective.

How to keep common coding manuals currently updated and distributed on a timely basis to thousands of providers and other persons involved with Medicaid and Medicare.

The use by third party payors of diagnosis and procedure codes to obtain uniform statistics has to be resolved. In resolving this issue, cooperation with some of the carriers, intermediaries and fiscal agents will have to be obtained. Unless the latter is accomplished, the basic issue might be difficult to resolve.

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Key Issues/Points Discussed

Medicaid Reimbursement: States unwilling to reimburse Rural Health Clinics using Medicare methodology, prefer reimbursement at lower rates.

State input needed in any proposed reimbursement regulations.

States' Concerns/Questions

Lack of Federal regulatory control of those performing laboratory testing in Rural Health Clinics.

How are prescriptions written when there is no physician present? What is Federal regulation or guide on this?

Federal Concerns/Questions

Development of prospective reimbursement system.

Legislation does not appear to have increased access to health care.

Unresolved Issues

States' concerns above remain unresolved issues. As these are HSQB responsibilities, we will be asking HSQB to clarify these issues for the States.

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Key Issues/Points Discussed

The major goals of the Division of Alternative Reimbursement Systems, BPP, HCFA are to:

- Streamline the review and approval process for Long Term Care reimbursement plans; and
- Compile more data to support State plans.

The Illinois and West Virginia Prospective Nursing Home Reimbursement Plans:

- Both plans formulate reimbursement on individual patient needs point system;
- The Illinois reimbursement plan is based on individual patient needs, not at the level of dollars expended, which assures that patients with more severe needs can be placed by structuring the rate to individual needs; and
- The West Virginia representative described the two theories of reimbursement as lumpers which base total reimbursement on total cost of like providers and splitters which base reimbursement on a combination of rates within each facility.

States' Concerns/Questions

Does the West Virginia methodology control costs other than nursing services? Yes, by class CAPS.

Is a minimum number of nursing hours required for each level of care? No, the number of hours is based on specific patient needs. ICF and SNF classifications are not arbitrary and do not define actual needs.

Will the point system result in greater patient dependency, to amass more points for reimbursement? No, if the plan is properly monitored, the West Virginia plan includes a premimum for restorative nursing services.

Has the 249:30 legislation resulted in more available beds? Yes, in Mississippi and West Virginia.

How can States operate within their budget and control the program expenditures based on a conscious decision by a State legislature in the allocation of scarce resources if a reduced budget is not accepted as a valid reason to amend the State nursing home reimbursement plan to contain costs?

HCFA takes the position that a budget decision within a State may be a motivating factor to look within the State's budget for areas where potential cut backs could be accomplished. However, the justification for amending the actual payment rate must be based on factors that are reasonably related to the cost of providing efficiently and economically delivered services.

Unresolved Issues

Philosophical discussion on whether the return to a nursing home should be based on patient services or investment? Is the nursing home industry a free enterprise or a quasi-public industry?

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Key Issues/Points Discussed

Base Period Indicators

Michel Amendment

- Amendment broadens the Secretary's waiver authority.
- Implementation of the Amendment with its 4% error rate and the upcoming congressional hearings on quality control.

Corrective Action

- To reduce erroneous payments.
- Importance of reviewing Corrective Action Plans.
- Need to continue working with the States on their Corrective Action Plans.

States' Concerns/Questions

The difficutly of applying equal treatment for all States in arriving at the 4% error rate.

Basically agree with Central Office MQC initiatives.

Importance of developing regulations for the "Good Faith Clause."

Federal Concerns/Questions

Regional Office wants and perhaps should be more involved in the initiatives for Corrective Action rather than emanating from Central Office.

Review Methodology: (a) definition of technical errors, (b) gravity of misspent money errors, (c) importance of getting out a manual to the quality reviewers.

Third Party Review/need to develop Quality Control Techniques for third party review operations.

EPSDT/emphasis and remind staff of October 1 effective date.

Utilization Control/the importance of the reviewer documenting what he/she discovers at the facility. More emphasis has to be placed on exit interviews.

Error rate/description of what comprises the Medicaid eligibility rate.

Unresolved Issues

Announcement of the error rate.

Preparation of a manual for use by the Quality Reviewers.

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SEMINAR ON PROGRAM PERFORMANCE STANDARDS AND STATE ASSESSMENTS

Key Issues/Points Discussed

Current issues and plans for integrating program performance standards with State assessments include:

- The relationship of program measures to the Medicaid Minimum Data Set (MMDS);
- HCFA's current direction regarding program performance standards and State assessments;
- The current status of the development of program performance standards; and
- Medicaid Management Information Systems (MMIS) recertification.

State Assessments are to provide the capability for:

- An early detection system to identify problems in a State;
- A measure to be able to determine how effectively a State is managing its program;
- Assessing a State's compliance with Federal regulations and laws; and
- Assuring that Federal Financial Participation (FFP) is being correctly claimed.

Overall, "State assessments are being redesigned with a view toward making them more result-oriented." The following approaches were outlined:

- State assessments will be an objective performance measurement review. Reviews will be structured in certain areas and will be output oriented;
- Assessment visits to States will be on a periodic basis throughout the year;
- Reviews and reports will be on an annual basis;
- States will be "graded" in five or six specific areas;
- Standards are currently being developed that will be used to measure a State's performance; and
- It is expected that the MMDS will be "on line" in January, and should provide HCFA with sufficient data to measure certain performance areas.

Program performance standards were being developed with major emphasis on two important program areas:

- o Objective standards that will enable determining States' cost, speed and accuracy of claims processing; and

- o Program measures which will be less objective, but will permit measuring how well a State is carrying out program objectives.

MMIS recertification will be accomplished partially through State assessment reviews. Output of a State's system will be analyzed to determine how effectively it is working.

States' Concerns/Questions

There appeared to be a consensus that in the process of developing program performance standards and State assessment measures, the following should be taken into consideration:

- o States need more technical assistance from qualified HCFA staff;

- o The development of program performance standards must be a positive joint Federal/State effort. States should be asked to review and provide input to the proposed standards before they are issued in final;

- o State programs do need improvement, but, overall, Medicaid is not grossly mismanaged;

- o State assessments are basically a good idea and long overdue. However, it can become grossly ineffective if overdone;

- o The question about the legal basis for MMIS decertifications;

- o There was a consensus that a lot of work has been done in developing program performance standards. Strong concern was expressed that HCFA is expending its total effort in measuring 6% of total expenditures, while ignoring 94% representing payment for services (e.g., how effective is the health and well being of people being improved through Medicaid?);

- o Program performance standards must be developed with a view toward enabling all States to have an equal chance to meet such measures;

- o Regarding MMIS, HCFA should structure its certification process and recertification plans so that each individual subsystem can be evaluated independently;

- o Program performance standards used for purpose of MMIS recertification should be applied equitably and uniformly from system to system and State to State;

- o HCFA should analyze its need for data before requesting it;
- o States uniformly were in agreement that State assessments should be done bi-annually using a concentrated team approach;
- o HCFA should evaluate the cost-effectiveness of its monitoring and assessment activities; and
- o Concern was expressed regarding the number of Federal staff reviewing States' operations and the frequency of such visits.

Unresolved Issues

Program performance standards are yet to be finalized.

There are questions regarding MMIS recertification that must be resolved.

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SEMINAR ON MMIS PERFORMANCE STANDARDS, NATIONAL TECHNICAL ADVISORY GROUP TASK FORCE REPORT, TIMELY CLAIMS PAYMENT

Key Issues/Points Discussed

Role and history of TAG.

Need for standards and how they will be used.

Use of standards to meet requirements of Federal Financial Participation (FFP).

Use of MEQC to measure effectiveness of claims processing and program management.

Effectiveness of standards for cost containment, fraud and abuse control, and program management.

States' Concerns/Questions

Lack of State representation at seminar and lack of participation.

Question of objectiveness of standards, how to be applied, impact on FFP.

Impact on Claims Processing Systems not MMIS certified.

Federal Concerns/Questions

Will standards properly applied result in better program management?

Too much emphasis on data elements rather than providing better management reports.

Are changes in program within last few years reflected by these data elements?

Impact of the Schweiker amendment on standards.

Unresolved Issues

Extent of and need of management reports.

How decisions are made regarding how to design and operate a Claims Processing System acceptable to HCFA and States.

How to obtain consensus and transfer information to States uniformly.

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SEMINAR ON MEDICAID BUDGETING, FINANCIAL MANAGEMENT AND ADMINISTRATIVE COST

Key Issues/Points Discussed

Federal Budgeting Process - HCFA will submit the largest supplemental appropriation request ever submitted for Medicaid in FY 1980. FY 1979 required the use of $500/600 million in FY 1980 funds caused by various factors including the use of a national model for Medicaid budgeting in lieu of the traditional State estimates on the OA 25.

Checks Paid Letter of Credit - HCFA will initiate a new Medicaid Letter of Credit system based on the current Medicare system reducing the float of Federal funds and providing significant savings in interest to the U.S. Treasury.

Bureau of Program Operations - BPO has a high priority to improve the budget and administration process for Medicaid, including the processing of Expenditure Reports and Grant Award Estimates at the State, Regional and Central Office levels.

States' Concerns/Questions

Has the budget problem caused an apparent conflict in Federal and State initiatives to control costs? Number of States feel control can be exerted at the State level.

Will State budgets and their performance be monitored? Yes, to explain potential future supplemental budget requests.

Is it legal to only implement the new Letter of Credit process in 10 States? This puts a penalty on only 10 States in FY 1980. HCFA lawyers do not agree.

How can the 10 States make up the loss in interest if the new Letter of Credit process is implemented in FY 1980 and State budgets have already been submitted? They cannot make up the loss.

Will this Letter of Credit process satisfy the requirement of the laws in some States which require Federal funds to be available prior to issuing checks? General Counsel believes this system will meet the requirement for availability as the Letter of Credit guarantees cash will be available when the checks are presented for payment.

Federal Concerns/Questions

What can the Federal government do to modify the MMIS reports to provide budget data in new designs? This is to be reviewed.

Unresolved Issues

If the OA 25 annual estimates get more attention, can the quarterly grant award requests be eliminated? This is being reviewed by the budgeting process as well as changes to the Letter of Credit process.

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